MENTAL HEALTH

PUBLISHED BY THE NATIONAL ASSOCIATION FOR MENTAL HEALTH
MAURICE CRAIG HOUSE · 39 QUEEN ANNE STREET · LONDON · W.1

PRICE 1/6 ANNUAL SUBSCRIPTION POST FREE 5/-

Vol. X WINTER 1950-1 No. 2

NATIONAL ASSOCIATION FOR MENTAL HEALTH

Regional Representatives

London Miss C. Hay-Shaw, 39 Queen Anne Street, London, W.1.

North East Miss E. Carbery, 129 Clayton Street, Newcastle-on-Tyne 1.

LOCAL ASSOCIATIONS

Birmingham and Midland Branch, N.A.M.H.
Hon. Secretary, Mr. T. Rankin, 40 Carpenter Road, Birmingham 15.

Bournemouth Association for Mental Health
Hon. Secretary, Miss Haskett-Smith, Spurfield, Danecourt Road, Parkstone, Dorset.

Buckinghamshire Voluntary Association for Mental Welfare
Secretary, Miss K. Jowett, County Offices, Aylesbury.

Cambridgeshire Mental Welfare Association
Secretary, Mrs. Lawrence, 2 Jesus Lane, Cambridge.

Derby Mental Welfare Association
Hon. Secretary, Miss M. G. Adams, Council House, Derby.

Devon and Exeter Association for Mental Health
Joint Secretaries: Miss F. M. Dickinson and Miss J. H. MacMichael, Ridgeway Close, Ottery St. Mary.

Dorset Mental Welfare Association
Hon. Secretary, Mrs. Hare, Frome Vauchurch House, near Dorchester.

Durham Mental Health Association
Hon. Secretary, Miss H. S. Cooper-Hodgson, M.B.E., 33 South Street, Durham City.

East Sussex Mental Welfare Association
Organising Secretary, Miss Nancy Biggs, 7 St. Anne's Terrace, Lewes.

Hants Voluntary Association for Mental Welfare
Secretary, Miss D. Alcock, The Castle, Winchester.

Hastings Mental Welfare Association
Secretary, Miss W. C. Rogers, 44 Wellington Square, Hastings.

Ipswich Mental Welfare Association
Secretary, Miss V. M. Burdett, 16 Charles Street, Ipswich.

Nottingham Association for Mental Health
Secretary, Mr. J. E. Westmoreland, 136 Mansfield Road, Nottingham.

Oldham Council for Mental Health
Hon. Secretary, Mr. A. White, 20 New Road, Oldham, Lancs.

Oxford Mental Welfare Association
Secretary, Miss M. R. H. Buck, Ebor House, Blue Boar Street, Oxford.

Sheffield Mental Welfare Association
Secretary, Miss W. Stirgess, School Clinic, Orchard Street, Sheffield.

Somerset Mental Welfare Association
Secretary, Mr. C. E. Newman, County Hall, Taunton.

Staffordshire Mental Welfare Association
Secretary, Miss F. H. Tosh, B.A., Crabbery Chambers, Crabbery Street, Stafford.

Tunbridge Wells and West Kent
Apply to: Adult Education Centre, Culverden House, Tunbridge Wells.

Walsall Mental Welfare Association
Secretary, Miss F. Grant, Room 21, Council House, Walsall.

West Lancashire Mental Welfare Association
Secretary, Miss F. Andrew, 8 The Grove, Waterloo Liverpool 22.

Windsor Mental Health Association
Hon. Secretary, Mr. J. H. Wallis, 10 Peascod Street, Windsor.

Wisbech Voluntary Association for Mental Welfare
Hon. Secretary, Mr. V. E. Webb, Health Dept., County Hall, March, Cambs.

Wolverhampton Mental Welfare Association
Secretary, Miss E. Bottomley, Town Hall, Wolverhampton.

Worthing Association for Mental Welfare
Hon. Secretary, Miss Nevell, 113 Marine Parade, Worthing.

For Child Guidance Clinics, consult Directory obtainable from National Association for Mental Health. Price 1s. 6d. post free.

MENTAL HEALTH

EDITOR: R. F. TREDGOLD, M.D., D.P.M.

PUBLISHED BY THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

Vol. X No. 2 WINTER 1950-1 Price 1/6

Contents

Editorial

One of the most significant changes in the mental health field has been the change in the attitude of the medical staff of many mental hospitals to their work, and—partly no doubt, as a result—the change in the attitude of the general public both to the medical staff themselves and to the work they do. Stocktaking in this respect is valuable from time to time and at the present moment is even more important since memories in these strenuous days are short ; we are therefore very grateful to Dr. Masefield for his comprehensive and carefully drawn survey of the history of mental hospitals, the first part of which is published in this issue to be followed by the second part in the next.

We have of course left well behind us the bad old days when mental hospitals were merely a repository for the incurable, and doctors merely there to care for their physical health and to write regular reports on their bizarre delusions—or perhaps to copy their predecessor's notes every six months. There has been a change from custodial care to treatment—and modern methods of treatment, physical and psychological, have completely revolutionized the situation, putting tools into the hands of the doctors which enable them to get into touch with a large majority instead of, as previously, only a small minority of their patients. Naturally this has meant that there is actually far more now for the doctor to do for any one patient—since many more than before have been encouraged to seek treatment.

But this is not all—indeed it is only the first step. Most mental hospitals have become more than " hospitals ". They have become centres for local out-patient clinics, the value of which, to the neighbourhood and to the mental hospital staff, is obvious enough, though the time consumed by them tends to be forgotten. Again, advice on preventive medicine may be sought from the psychiatrist by general practitioners, medical officers of health, nurses and social workers in many fields; so that an out-patient clinic is by no means the only extra-mural work to be done. No doubt, much of this can be carried out by psychiatrists who are not in mental hospitals but in the country areas, at least, these are few.

With all this, the attitude of the public has changed, and is still changing: the recovery of many patients, the removal of restraints, the vastly increased use of occupational treatment, the pleasant aspect of new wings and villas, have all gone some way to break down the age-long fear of incurable mental illness and to banish the tragic stigma of having been inside (or having had a relation inside) a mental hospital. The man in the street thinks far more about mental health than before, and even if some of his ideas on psychiatry and in particular on psychiatrists, owe rather more to Hollywood than to Harley Street (or to the Maudsley), it is certain that his fears and prejudices have lessened. In Sweden, one is told, the stigma has been abolished in the past 20 years, as a result of just those improvements which are here listed; and if this is true, it may be regarded as one of the major advances in psychiatry.

As Dr. Masefield shows, these changes have been accomplished by a process of gradual development—and perhaps because it has been gradual it is worth while emphasizing that the amount of work which can be done now is many times greater than even 20 years ago and—important to note—is still increasing. There are few psychiatrists nowadays who are not overworked; few who do not feel they could do more if only they had the time. The mental hospital doctor who played three rounds of golf a week may have existed in 1930; if he manages a game a month now, he is lucky.

Unfortunately these new developments and needs cannot be universally known: or it would be impossible to understand how those who frame our destinies could casually include psychiatry in the field of general medicine where the vital posts of registrars—consultants in training—are being abolished because there seems no prospect of consultant posts being available. If no consultants are trained, treatment (in-patient and out-patient) will be widely curtailed, prevention and research checked, and the tools we have allowed to rust unburnished will never shine in use. Hope and confidence in the future will disappear, and we shall slip back into the darkness of despair, prejudice and custodial care—all the more tragically because of the fact that an enlightened future was once shown to us as possible.

The Progress of Mental Hospitals. I

By W. GORDON MASEFIELD, C.B.E., M.R.C.S., L.R.C.P., D.P.M.

The subject matter of this Paper has been adapted from one which I was asked to prepare and read, some months ago, to my medical colleagues of the Royal Medico-Psychological Association under the title " Medical Administration in Psychiatric Hospitals under the National Health Service ". You will not, I think, feel insulted if I call you a mixed audience with many and varying points of view—partly lay and partly medical—but we all meet on common ground in our interest in the many-sided activities of the Mental Health Service and in particular the ever-expanding work of Mental Hospitals.

May I, at the outset, try to make sure that we all understand just what is meant by the word " psychiatry "—for me, at any rate, it means that branch of medicine which is concerned with the prevention, causation and treatment of deviations of human behaviour. By using the word " deviations " it presupposes that there is such a thing as *normal* human behaviour—and the best one can do about defining that, is to say that normal behaviour depends on the reasonably successful adjustment of the individual to his surroundings, i.e. he is in harmony with his environment as far as may reasonably be expected—because, I hasten to say, an uninterrupted and perfect adjustment cannot be expected of any human being—after all, human relationships tend to be very complicated for us all. Still, behaviour is the standard by which we judge the ability of an individual to lead a community life or to be in need of help and treatment in so doing, although there is no real dividing line between normal and abnormal behaviour, nor is there any true distinction between what is socially acceptable and what is not.

Earlier Prejudice

Unfortunately the separation of psychiatry (this special branch of medicine) from general medicine was for long almost complete and those engaged in the care and treatment of persons who showed severe degrees of abnormal behaviour, i.e. persons of unsound mind, were looked upon as people apart almost as much as were their patients. We have, however, made considerable progress in the right direction but still popular prejudice is kept up in some quarters by the continued use of such out-of-date terms as " Lunatic " and " Asylum " or phrases such as " kept under lock and key ", " put away ", and " prevention of escape ". Ignorance and fear combined have tended to maintain lingering prejudices which originated, to some extent, in legislation which could only suggest that mental illness was in the nature of a crime. The result of such a method of dealing with this form of malady was, fairly naturally, the refusal, or at any rate the great reluctance, of general practitioners, relatives and patients to acknowledge the existence of the illness. It is still by no means uncommon for early signs and symptoms to be either entirely disregarded or readily glossed over. For many years this was easily understood because, with the best will in the world, unfortunately little satisfactory remedial treatment could be offered—but happily this is far from being the case now.

We must, in considering the development of the mental health service, emphasize that the story of the progress of mental hospitals is a long one—they remain, however, the centres on which all the psychiatric services revolve and they must, while providing accommodation and treatment for all types of mental disorder, act as the main training grounds for the study of all stages of mental illness. Despite the value and importance of the work of the few homes and hospitals solely for early cases (neurosis centres) in this country, the idea that a well-planned, well-run and progressive mental hospital is not a suitable place for the treatment of early or mild cases is quite unacceptable and the suggestion that it can be looked upon as in any way a home for incurables should once and for all be relegated to the past. It is perfectly true that the story of the change and upgrading of pauper lunatic asylums, planned and built for detention and custodial care, into mental hospitals with the primary object of treatment and cure has been gradual and painfully slow. The reason is not far to seek—by its very nature mental illness is so complex that its understanding, still of course very imperfect, has perforce emerged very slowly—we may, however, claim quite fairly that

psychiatry is now growing up, and year by year gaining in stature and experience.

Nevertheless we all know that the period of adolescence carries with it a very real danger —that of youthful cocksureness—the idea of omniscience. It is very essential that we remain on our guard lest we claim that psychiatry can achieve more than is reasonably possible in our present state of knowledge; and what of the so-called experts in psychiatry, the psychiatrists? They are called by many names—not all by any means of a flattering type—and to some they appear to delight in a language of their own. By some they are termed witch-doctors—this of course is evidence of the unconscious fear resulting from lack of knowledge, but I admit that it may quite reasonably have some reference to the harsh-sounding polysyllables and forms of incantation with which some psychiatrists are wont to fill the reports and descriptions of their cases !

Historical Account

It is, I think, of interest, when considering the present-day position of mental hospitals and in particular the changes which have taken place under the National Health Service, first to give some consideration to the history of the early days of the care of the mentally afflicted in this country—by so doing one obtains some sort of a realistic background.

The first place of care for the insane was Bethlem where in the year 1403 six lunatics were confined—Bethlem Hospital had been founded in 1247 but was then opened as a Priory and Hospital for sick and wounded Crusaders. In 1457 the chaplain to Henry VI, also a medical man, was appointed as " Master " at Bethlem and therefore may be looked upon as the first medical superintendent. Later, however, at the Reformation, changes were made and Bethlem was administered by a " Keeper ". At this time Martin Luther made the pronouncement that insanity was assuredly due to " demoniacal possession " and acting on this form of belief it was a common practice in this country to inflict daily whippings to beat out the evil spirit from the poor wretches. In the 17th century the great physician, Dr. Thomas Sydenham, prescribed for mania a cordial consisting of Venice treacle, which contained, among numerous other ingredients, the flesh and blood of vipers, and he strongly recommended bleeding with three days between each bleeding, followed by a course of purgatives. By this time Bethlem had gained much notoriety and was in fact one of the sights of London—many thousands of persons visiting there each year on payment of not less than 2d. per head. Throughout the 17th and most of the 18th century there was little improvement in the conditions of the insane. The need for their accommodation did not become very pressing until, with the growth of the population, there was a considerable increase in their numbers. When the time came necessitating buildings to be provided for housing them, they were but prisons of the worst description. Attendants were armed with whips and were free to impose manacles, chains and stripes at will. One could readily imagine that the lot of the wandering lunatic was preferable to being confined under such conditions. Reforms were, however, at hand, and Pinel in Paris and Tuke in York are the outstanding names. The latter's efforts resulted in the building of the York Retreat in 1792. It must be remembered that four years previously (1788) King George III had become mentally deranged and great public indignation was aroused by the type of rough and ready treatment which he was compelled to undergo. Between 1837 and 1840 the first attempts were made in this country to abolish " mechanical restraint " (chains, hobbles, leg locks, hand straps and strait waistcoats) in public asylums by Dr. Gardiner Hill at the Lincoln Asylum (built in 1819) and Dr. Connolly at Hanwell (built 1831). By 1845 Dr. Connolly wrote in his Report, " There is no Asylum in the world in which all mechanical restraints may not be abolished, not only with perfect safety, but with incalculable advantage." Nevertheless other medical superintendents denounced it as impracticable and utopian. It was in this same year (1845) that a Lunacy Act was passed making the provision of lunatic asylums by local authorities (in those days Committees of Magistrates) compulsory, and the medical character of such county asylums was for the first time publicly assured by placing them under the management of a resident medical superintendent. The Commissioners in Lunacy were appointed, with Lord Shaftesbury as chairman, in the same year. It is of interest, I think, to attempt to gather from medical superintendents' own words the current opinion of asylum aims at various periods. In 1864 the medical superintendent of Gloucester Lunatic Asylum of 600 beds wrote, " The four points in asylum management which the superintendent is most interested in are (1) Moral Influence, (2) Classification, (3) Health and Comfort of the Patients, and (4) Economy

of Management." By moral influence was meant the humane and kindly treatment of the patient in as rational a manner as his state of mind would allow, the elimination of all force up to the point of safety, the use of occupation and recreation and the stimulation of self-esteem in the patient. This was undoubtedly a praiseworthy advance in the humane management as compared with the former use of restraint, purging, bleeding, vomiting and blistering. But at this early stage and for many years after, such enlightened ideas were the exception and not the rule—the staff remained completely untrained and the medical officers were occupied almost entirely in treating physical ailments and accidents.

As a proof, however, that in those early days the post of a medical superintendent of a public asylum carried with it real satisfaction for a man of high integrity and of unusual vision, Dr. Henry Maudsley (the benefactor whose memory is kept alive by the Hospital which bears his name) in a memoir of that great reformer John Connolly of Hanwell said, " I have often heard him say that if his life was to come over again he should like nothing better than to be at the head of a large public asylum in order to superintend its administration." Such a sentiment certainly in his case did not arise from a love of power for its own sake ! By 1884 a medical superintendent writes, " Our duty as medical officers of asylums stands in the following relations: (1) To preserve and to do all we can to lengthen the lives of our patients, (2) To promote recovery by all reasonable and legal means, (3) To do this in the most pleasant manner for our patients with the greatest regard for their comfort and happiness." These were certainly most estimable aims and it is sad to think how restricted were the means of curative treatment—although at this period the increasing knowledge of anatomy and physiology of the nervous system and the discovery of microscopic germs as the cause of many diseases was gradually leading to a better understanding at any rate of mental reactions of toxic and organic kind.

Medical Staff

For an asylum of 1,000 beds at this time two assistant medical officers were considered adequate in addition to the superintendent who was physician in charge and chief executive officer, with control over all personnel and management of the whole institution. In the last quarter of the 19th century much was done to improve the care of the patients by those in attendance upon them. Wardresses and keepers were gradually converted into nurses and attendants and systematic training was begun. In a report of the medical superintendent of one of the older asylums the statement was made that, " The idea that keepers require great physical strength and therefore large quantities of animal food to support it is wrong. Gentleness and tact, which can only be acquired by long training have proved much more effective." In those days there was no separate night staff; patients and staff slept in the same dormitories and, if thought necessary, nurses had to sit up part of the night to attend special cases—even when attendants were allowed bedrooms of their own these were provided adjoining patients' dormitories with windows overlooking the patients' beds so that the nurse could not rest by night assured that she would remain undisturbed. Such an extraordinary form of planning was in evidence until comparatively recent times.

There was still as yet no organization of specialized training for medical officers, only exceptionally by their own initiative, observation and clinical acumen did some show particular aptitude for the work and so qualify for the higher posts. The medical hierarchical system (as the A.M.O.s increased in number) became steadily more in evidence and promotion by seniority of service was the rule. Medical superintendents of some of the larger asylums tended to become dictators and far too autocratic in their own sphere of influence. Competitive statistics were looked upon as the main criteria of satisfactory administration.

My own first personal experience of work in a large mental hospital was, very nearly forty years ago, in one where the medical superintendent had a great reputation as a most successful administrator and had recently received the honour of knighthood. What is my chief memory ? It is a lecture from the medical superintendent on the subject of avoiding a surgical operation on a patient if at all possible owing to the risk of an inquest if things did not go right—and consequent adverse criticism of the hospital !

In a reference to the medical set-up of the early 20th century asylums I find these phrases: " Within the sections of the Asylum the Assistant Physician must be free to arrange the routine while the Superintendent acts as Consultant. Comparing the man in the Asylum Service with others who have received a thorough

academic training, I find that most of the latter have a much more independent position than the Asylum Assistant Physician and I suggest that the lack of independence could be rectified by combined effort and mutual goodwill of Superintendent and Assistant Physician—but (he concludes) the administrative authority must be maintained." That which was written nearly fifty years ago appears to be well worthy of note today.

The question of how far an asylum (or mental hospital) can be run on general hospital lines is by no means a subject of recent discussion only. In 1902 Dr. R. M. Robertson, then Medical Superintendent of Stirling District Asylum at Larbert—at all times an ardent enthusiast—said, "The dominating principle is the desire to make the asylum a medical institution worked on the same medical principles and with the same nursing ideals as our large general hospitals. To give full effect to this principle there are not only many things to be done but much to be undone, for asylum treatment of the insane, to its great misfortune, has a past. It has been my object to abolish as far as possible features peculiar to asylums and shown to be injurious or unnecessary, to elevate the standard of nursing and duty to that of a general hospital and to make an asylum for the insane in reality a hospital for the treatment of a special disease run on hospital lines under the supervision of fully-trained hospital nurses." In the paper from which these quotations are taken Dr. Robertson was advocating particularly the appointment of general trained nurses as assistant matrons, the employment of female nurses in male wards, the increase of nursing staff by night and condemning, what he termed, "the abuse of single rooms". It is, I think, salutary to be reminded that some of the progressive ideas which we have fondly imagined to be products of our own minds were put forward so many years ago.

Again in 1904 we find a superintendent in Ireland writing a paper in which he urges the boarding-out in family care, under due safeguards, of the chronic and harmless type of asylum inmates—he puts it thus—"The object of an asylum should be to form a hospital for the cure of the curable, for the treatment of the sick, for the safeguarding of those who cannot be allowed to be at large and for the amelioration and thorough study of the condition of such patients as can eventually, under proper regulations, be restored to family life, with a fair measure of safety, though uncured. We should not retain the inmates any longer than is manifestly for their good, irrespective of their usefulness in the Institution." I think we can agree that those phrases require little alteration to bring them up to date—and it is a useful reminder that all long-term cases should come under full and careful review periodically.

Diploma in Psychological Medicine

By 1911 the Diploma in Psychiatry or Psychological Medicine was instituted in various Universities, the first being Edinburgh, Durham, Manchester and Leeds—and Dr. Clouston (later Sir Thomas) said, "No man will hereafter venture to set up as a Consultant in Mental Diseases except he has this Diploma"—but in 1912 Dr. Bernard Hart had this serious criticism to put forward, "As regards the administration of asylums, the comfort of our patients and such like matters, Great Britain stands at any rate in the front rank even if it is not in advance of any other country. On the other hand from the point of view of scientific work and the professional status of the medical men who are concerned with this branch of medicine the position of Great Britain leaves much to be desired. Humanitarianism and the reforms which flow from it are very much in evidence in England but science seems to have gone elsewhere—owing to the lack of organization." That was a grave indictment indeed and I suspect that the fault lay, partly at any rate, in the fact that the medical staff of the asylums were so much cut off from other branches of medicine. At this period the question of the position of Assistant Medical Officers was much under discussion—especially their poor pay and prospects and particularly the unnatural insistence on celibate life. It was practically unknown for any form of married quarters to be provided for any member of the medical staff other than the superintendent, but such were provided for the clerk, engineer and (frequently) the chaplain. Nevertheless it was thought desirable in most cases that a medical superintendent on appointment should be married and the absurd situation arose that the majority of Senior A.M.O.s applying for a superintendent's post stated in their application "I am about to be married" or "I am willing to be married", which led one critic of the system to say, "Any man who becomes a Senior A.M.O. must consider it his duty to get a girl in tow and to keep her in tow for five or six years although he may never be able to marry"!

The methods of appointment of medical superintendents also came under serious criticism—being considered unsatisfactory because made by lay committees who were not always willing to accept expert advice, the appointments often being made by local influence and sometimes with little reference to professional ability and attainments.

New Legislation

During the war years 1914-18 the evolution of asylums stood still, medical staffs were down to the barest minimum and the most progressive medical superintendent could only look to the future, cope with his numerous administrative problems and read and study the fascinating psycho-pathological theories and discoveries of Freud and others. But once the war was over development was rapid, young and keen men (and women) were attracted to mental hospitals now endeavouring to justify the new title, nursing staff of each sex was recruited of better quality, conditions of service were improved, out-patient work was instituted and thought concentrated on more enlightened legislation. New methods of approach to the individual patient were perhaps the most striking result of the early years after the first world war. In all of this the younger members of the medical staff took an increasingly interested part, and I think it is true to say that the medical superintendents appointed in the between-the-wars years tended to be less autocratic and individualistic than, speaking generally, were their predecessors. The Royal Commission on Lunacy and Mental Disorder of 1926 reviewed and reported on the whole question of the relationship of mental hospitals to the public and many of its far-seeing recommendations were, after much debate, embodied in the Mental Treatment Act 1930.

Mental medicine was thus brought a step or two nearer to general medicine. The reputation of most mental hospitals in the eyes of the public was enhanced by the introduction of a number of modern methods of treatment and the expansion of psychiatric out-patient clinics in general hospitals. Medical superintendents on the whole devoted more of their time to clinical work and less to purely administrative duties—more reliance being placed on and independence granted to responsible heads of departments in the institution. Then war came again and the cream of the younger psychiatrists were soon required in the fighting services and so the hospitals were denuded of their coming men. For medical superintendents details of administration complicated by war conditions overshadowed all other considerations and adaptation to E.M.S. and other service requirements was for many the prime necessity. I venture to think that the country was fortunate in having ready-made medical administrators of experience for these purposes. Although active treatment of civilian mental patients was of necessity retarded—nevertheless the mingling of general physicians (and surgeons) with hospital psychiatrists was a circumstance which was of benefit to all concerned. During this war period the prospect of a comprehensive National Health Service in the near future stimulated all those especially interested to ensure, if possible, that mental health in the new service should not only be included but should have a place in keeping with its increasing importance. This prompted the drawing of a Memorandum on the Future Organization of the Psychiatric Services which in its final form was the joint product of a representative committee, including all shades of psychiatric opinion, appointed by the Royal College of Physicians, the British Medical Association and the Royal Medico-Psychological Association. The following are two of the recommendations: "Unless and until the mental hospitals and mental deficiency institutions are organized on the same lines as the voluntary hospitals there should be a medical superintendent in charge of each hospital who should be in continual touch with the clinical aspects of the hospital and its patients. The position which imposes complete legal responsibility on medical superintendents for all patients in the institution under their care should be reviewed"; and "In each hospital there should be a medical committee composed of members of the staff, including visiting consultants. The views of the Medical Committee on medical and administrative matters should be transmitted to the controlling lay authority normally through the medical superintendent who should have a duty to convey them."

On the whole, I believe it is true to say that the sections of the National Health Service Act which deal with mental health and the consequent regulations have followed very closely the recommendations of this joint memorandum.

(To be concluded.)

Occupational Therapy

By J. K. COLLIER LAING, M.B., B.S.(Melb.), D.P.M.
Medical Superintendent, Darenth Park, Dartford, Kent.

Definition

Briefly and strictly, Occupational Therapy may be defined as any activity, mental or physical, medically prescribed and professionally guided to aid a patient in recovery from disease, or injury, or in the development of latent but retarded capabilities.

Therapy means treatment, and since the physician or surgeon is the recognized authority in caring for disabilities, efforts to correct them should be under his supervision. Close co-operation by the therapist with the nurses, physiotherapists, trainers and instructors is highly desirable.

Scope

The procedures that may be useful therapeutically are without number, the only limitation being the specific need of the individual patient, from both the psychological and physiological viewpoints. The active interest and co-operation of the patient is a great help, and in the early stages every effort to arouse these should be made. Although stress is placed upon the individual needs of each patient, there are many patients whose needs are similar and these can well be treated in groups.

Occupational Therapy is not vocational training but it helps towards that end. Work tolerance, work habits and muscular and intellectual abilities can be determined by its use.

Application

An interesting experiment has been going on for some months at Darenth Park. Two Medical Research Council psychologists from the Maudsley Hospital, having worked out the I.Q.s of over 100 boys with various standard intelligence tests, and having correlated them with the findings of a consultant psychiatrist, are busy measuring the working capacities of these patients in a variety of jobs supplied by outside firms. Before awkward questions are asked, let me say now that the arrangements were all made with the concurrence of the Ministries of Health, of Labour and of National Service. I shall return to these experiments later.

While the needs of patients in general and mental hospitals differ to a certain extent, there is a great deal of overlapping and this applies especially to those hospitals which house long-term patients—chronic sick and tubercular patients, for example. Preston Hall Sanatorium near Maidstone in Kent has developed its occupations to cover an enormous field and, incidentally, a very paying field. In general hospitals with short-term patients there are many cases who have anxieties, discomforts and time to worry. These can be mitigated by light, interesting short-time activities which can be carried out while the patient is in bed. This applies as well to maternity cases (especially the unmarried) who have complications leading to long rest in bed before and after delivery. Longer term orthopaedic cases and patients with injuries, burns, cases of nervous disease, poliomyelitis, partial paralysis and so on, can be given occupations devised to meet their individual needs by the doctor indicating the muscles and joints that he wants exercised to the therapist who should be able to provide an interesting occupation to meet the requirements. As illustrations, light basketry, clay modelling, cutting with scissors, are activities which exercise the muscles of the fingers and thumb; the wrist is exercised by doing block printing and braid weaving; the forearm by screwing, weaving, wringing clothes; the elbow and shoulder by sawing, planing, painting, printing; and treadle industries such as a potter's wheel or printing machine exercise the hip, knee and ankle; gardening or painting do the same for back and standing muscles.

By ingenuity and co-operation between the therapist and doctor, interesting occupations can be devised for almost any patient.

But, you may say, this is not of interest to those who have to cope with ordinary healthy mental defectives or delinquents. We shall come to these. In a hospital for mental defectives of all kinds there are many who are paralysed, some are blind, others have physical illnesses, and what applies to patients in general hospitals largely applies to these and others with physical handicaps. In one of my wards housing epileptics, cardiac cases, deaf and dumb patients,

and physically handicapped patients, three are quite blind, three almost blind and one partly blind; five have choreoathetosis, five have paraplegia, three hemiplegia, one monoplegia, one an amputated right leg and one acromegaly. None of them has an I.Q. of over 60, but most under 50; yet they are tremendously happy all day making things at their own pace. In this ward our aim is to have such a variety of work that every patient is attracted to something and many of them do more than one job. Last year they made 50 woollen rugs, 20 cushions, 32 baskets, 6 scarves (loom work), 12 boat lamps, 117 stools, 30 fire screens, 25 lampshades, 290 knitted scrubbers, as well as trays, slippers, mats and other articles.

They also made mechanical toys and Christmas crackers. At the annual staff children's party, each of 168 children received a substantial and workable toy made by these patients; some of the younger ones made toys for their smaller brothers or sisters which they handed to them with enormous pride. The articles sold during the year brought in £370 10s., but although useful this is insignificant; the contentment and happiness of these patients is what really matters and has to be seen to be believed. One patient (the monoplegic whose left arm is completely paralysed and spastic) was for quite a long time a persistent window smasher. We put him in this ward about a year ago, gave him lots of tins of paint and brushes, and he immediately became so interested in painting the finished articles that window smashing appears to be a thing of the past. Such a result could not be achieved without the enthusiasm of the charge nurses of the ward and the support of their seniors.

The paralysed girls who are at Darenth Park are mostly of higher grade than the boys. Their chief interests are crochet work and embroidery. They make exquisite articles. But the girls are exploited badly unless protected. I discovered years ago that visitors were in the habit of supplying crochet cotton to the patients who would spend months making, say, a magnificent tablecloth worth £10 or more and receive, perhaps, 5s. for their trouble. Control is essential.

Probably the lowest form of occupational therapy, but one which keeps the lowest grade imbecile girls quite happy and busy, is shredding thread by thread small pieces of material about 2 in. by 2 in. of bits left over when garments are made. The resulting handfuls of threads provides one of the best stuffing materials for soft toys.

Earlier on I remarked that occupational therapy was not vocational training. At this stage it might be of benefit to examine this statement more closely. All the work outlined before is strictly occupational therapy in that it has been given to the patients for the purpose of sustaining morale and overcoming the patient's preoccupation with his deficiency, mental and physical, and in order to prevent further deterioration in such thought processes as he may possess or in his conduct. It may sound pessimistic but it is obvious that very few of the types of patients mentioned will ever be likely to make a place in the world at large or be self-supporting and none of them are suitable for the workshops where training towards this end is provided.

There is no clear line of demarcation. Occupational therapy can and does lead into the more utilitarian forms of training and can be most valuable in arousing interest, indicating aptitudes and developing work habits.

But as I am here dealing with this subject " in its widest sense ", I shall include some remarks on vocational treatment designed to help patients to become socially satisfactory and useful.

For a great many years *work* in or about a hospital or " workhouse " was all that mattered. Music and games were introduced much later —or rather reintroduced, for the ancient Greeks and Egyptians used these for the improvement of physical and mental health.

That work has a therapeutic value cannot be denied. It was frequently quoted to me in my youth: " Work is the greatest blessing God gave to man," " Change of work is as good as play," and some of the sayings of the old physicians underlined these aphorisms, for instance Galen (A.D. 172): " Employment is nature's best physician and is essential to human happiness." But work as such is not occupational therapy in its true sense, except in rare cases such as in one of my patients who is a Mongolian imbecile. He had been looked after by an older doting sister for many years after the death of his mother. Her health began to fail and she had to look round for some place where he could be cared for. After a minute inspection of this hospital she decided to give it a trial. She arrived with the patient, aged 54, and gave detailed instructions as to how he was to be dressed, the type and weight of the vests, pants, socks and shirts he was to wear, what he was to be given to eat, etc., even to insisting that the nurse must use cotton-wool always after the

patient had a bowel motion (she had always done this herself). After preliminary training in washing and dressing himself and the removal of a pile by the surgeon, this patient was soon taught to use toilet paper himself and to wash his hands afterwards. Like most Mongolians he is affectionate, and will do anything to win affection and approval. He therefore keeps himself scrupulously clean and tidy and nicely dressed, albeit in rather fantastic garments (plus-fours and yellow stockings) provided by his sister. A job of work was prescribed; he was given that of setting the tables for meals in his ward, and now, just 12 months after his admission, no tables in the hospital are better set with cutlery, crockery, mats, glasses and the rest in amazing precision. He is as proud as can be of what he has learned to do. In this case I think his job can be called occupational therapy, but I am sticking to my guns and repeat my opinion that work in or for a hospital is WORK, and that *the workers should be suitably rewarded.*

Workshops

In a great many medium grade feeble minded patients, distinction between those who are "custodial" and those who are "trainable" appears self-evident from the time of their admission, but good results occur from time to time in most unlikely patients. Some cases have spent 20 years and more at Darenth, but have in the end made the grade, have been licenced and ultimately discharged. However, repeated trials, changes of occupation over and over again, and infinite patience are required. Temperamental in addition to intellectual defects have to be taken into account as well as mal-adaptation in social sense.

Industrial workshops have been one of the features at Darenth Park for many years. In the male side, workshops patients are taught carpentry, joinery, wood-turning, upholstery, mattress making, printing, bookbinding, mat making, brush making, basket making, envelope making, paper bag and manilla folder making, boot and shoe repairing, tailoring, firewood cutting and bundling, painting and glazing, bricklaying, briquette making and cement block making. Toy making was highly popular when materials were available. These trades are all taught by skilled artisans.

Farm work appeals to many defectives and horticulture is widely covered by lectures, epidiascope and film shows as well as practical work. Male patients also work in the engineers' and boiler houses, in stores, kitchen, bakehouse, and with coal trimmers, refuse collectors and road repair works.

In the female workshops are taught sewing by hand and machine, cutting out, dress and uniform making, soft toy making, wool rug making, and the examination and packing of manufactured articles. In the laundry, female patients are taught laundry work of all kinds.

The shops cater for trainable defectives who not only benefit from the craft training they receive but from the stabilizing influences present. It is sad to relate nowadays the shops are mostly occupied by the "custodials" because of three main causes: one, the gradual silting up by patients who have been there for years, two, because so many patients unsuitable for the shops have had to be admitted, and three, because of a great increase in opportunities for licence for the patients who are suitable for trial. The shops show a profit which is variable. In 1947 the turnover was £52,000, in 1948 £112,000, and in 1949 £49,000.

The restless, young, delinquent types do not do well in these shops. They are constantly absconding and when in the shops they upset the other and more stabilized patients. So special shops had to be provided, about which more will be said later.

Once a patient has learned to make brushes, or mats, repair shoes, in fact become reasonably proficient in any trade, it is extremely difficult to get him to do anything else.

Another point of interest is that the girls who are keenest on laundry work are those who have histories of street-walking, prostitution, venereal disease. Possibly there is something to be said for Freud & Co. after all !

At Darenth, facilities do not exist for properly organized training of girls in domestic service, but as much is done in the Nurses' Home and wards, the girls who leave to take up service have had a good basic training. At Leytonstone House, with a female staffed kitchen, I was able to get the girls trained in cooking, sewing, waiting at table, taking and making telephone calls and so on.

Special shops for work brought in

Previously I referred to the Medical Research Council's psychologists and their efforts with boys upon work supplied (and paid for) by outside firms. It was not easy to find firms who would co-operate, but Kolster-Brandes and Hunt Brothers have been most helpful. The boys were for the most part persistent absconders

from approved schools and had exhibited many forms of anti-social behaviour, larceny, assault, house-breaking, and others. Kolster-Brandes sent people to show them how to do the jobs —filing, trimming, filling lettering and buffing parts of wireless and telephones, and other plastics; Hunt Brothers sent cardboard cuttings for fitting, stamped out cards for folding and gumming, and other similar work.

These delinquents have improved in an astounding way. Possibly the pay-incentive has a lot to do with it, but even more credit, I think, is due to the enthusiasm of the nursing staff assisting in the special shops and managing the boys in their wards, because even before the shops were opened the breakages and damage caused by these undisciplined and irresponsible youths had dropped by 75 per cent. in six months. None of them has run away and it has been possible to place a number of them on daily licence and parole.

This may not be occupational therapy in its narrow sense but it has been of remarkable therapeutic value.

Daily licence

Somewhat similar to the foregoing but in the reverse direction, is sending patients out to their occupations. Quite apart from the numbers of patients who go out to daily jobs of domestic work in homes or hotels, or who work in garages, gardens, etc., is another attempt to do something for the misfits of society. This consists of sending two or three coach-loads of patients (many of whom have C.R.O. (New Scotland Yard) numbers), with a staff nurse, to daily work at St. Paul's Cray where they are builders' labourers and canteen workers. It has given us the opportunity of testing many patients and provided us with much insight into individual behaviour. Some patients proved unequal to the work for physical reasons, others because they were work-shy or too clumsy, others because of contractors' foremen's temperamental difficulties. As many as 85 patients went to work at one time but to-day we are keeping the number round a steady 60. A social worker has had to attend frequently to sort out difficulties, change patients' job, give " pep talks " and to educate foremen. The firm of contractors (Holland, Hannen & Cubitt) has been very co-operative and sympathetic and has expressed the greatest satisfaction with the work done. Some foremen have told me they prefer to have my patients to those supplied by the Labour Exchange. Two of them are charge hands and teach the Labour Exchange men their jobs. Two have already gone on resident licence and more are expected to do so.

All are trade unionists, and all receive Trade Union rates of pay and many, bonus pay as well. The average pay packet after deductions is about £5 a week, but some reach £9 and more.

Geriatric Occupational Therapy

It is natural that occupational therapy has been chiefly directed towards making useful citizens and psychologically contented, the younger and middle-aged. Very little has been done for those who are ageing, but this is no reason why old people should not be kept happily occupied, feeling themselves still of use (as they long to be) and their minds diverted from the anticipation of early dissolution which they so clearly recognize in contemplative moments. What can be done to help ?

St. Pancras Hospital has gone further with this problem than anywhere else I have heard of, and I suggest that any of you who have to deal with these problems try to arrange a visit. I regret I have not yet been able to go myself. I understand that the old people who attend are not simply given jobs to do but that the occupational therapist, the physiotherapist and others assisting, work together to keep the old folk interested and entertained, and devise ingenious contrivances to prevent these people precipitating the down-grading of their physical and mental capacities. As an instance, one old man who has practically lost the use of his legs, weaves on a loom which has been constructed so that whenever he pulls on a bar with his hands, his feet and legs are so attached to it as to cause them to move, thus keeping up to some extent his muscle tone and circulation.

Occupational therapy for old people may be active or passive. The active forms are occupations such as knitting. When socks become too complicated, simple things like dish cloths can be knitted with larger needles and thick cotton or string (such as are useful for people with arthritic fingers). Woollen balls for children are also easy to make. Some of the older generation can do tatting, pillow-lace making, knitted lace making, crochet or patchwork quilts (friends can help by handing over their unwanted bits). Carpet making seems to appeal to Royalty. Games such as whist, euchre, halma, dominoes, word-making, can play a part and sing-songs and hymn singing very often appeal to groups. Old men often like to play at billiards, bowls and clock golf, while ambulant, but many love simply

to potter doing useless things but quite happily.

Passive occupational therapy for old people is illustrated by listening to the wireless, by having interesting books and plays read to them. So much depends upon the previous interests of each individual that the therapist must find out what these interests were and play upon them. Many old prople love to read the Bible (or to have the Bible read to them, especially their favourite passages). Here I am on delicate ground because I am not sure whether the therapist should not be the parson rather than the person who puts M.A.O.T. after her name. In any case the occupation under review tends to indicate that the patient is pre-occupied with problems outside the scope of this paper.

I have endeavoured to speak of occupational therapy in its widest sense, and have probably exceeded all bounds, but one more thing I would like to say, and that is, just as what may be used for occupational therapy is without limit so are the people who find occupational therapy of benefit.

For readers who would like to learn more about this subject there are books which can be recommended. The one by Willard and Spackman published in 1947 (Lippincott, 40s.) is probably the latest and I acknowledge that I am indebted in some ways to having read their book and noted some of its contents. I hope that this small paper may stimulate interest in its subject. I have to visit a number of hospitals and I have noted with appreciation the efforts of some of the smaller hospitals to provide some form of occupational therapy for their patients and the happiness of the patients so occupied, but I confess to having noticed very little in some other hospitals. I know that it is not the fault of any Superintendent but I hope it may be possible to stimulate those in authority to a realization of the value to the individual patient, short-term, long-term, chronic, tuberculous, neurotic, psychosomatic, defective or psychotic, of occupational therapy properly and skilfully applied.

Maintenance of Mental Health

5. ADOLESCENCE

By HOWARD JONES, B.Sc.(Econ.), D.P.A.
Psychiatric Social Worker.

Adolescence, that stormy period of transition from childhood to adult-hood, can hardly be said to have a beginning at all. For the changes which we call adolescence have begun long before we recognize their existence and give them a name. The roots of many of them lie deep in the earliest years of childhood.

Nevertheless, the time comes when the conflicts which these changes represent have become so sharpened that we are forced to realize that we have an adolescent child among us. We cannot say exactly when the transformation took place, but sometime after the age of 13 or 14 (a little earlier for girls than for boys), the typical symptoms are there for all to see. There is the gawky figure and the clumsiness. What a contrast to the graceful movements of the child of 9 or 10 ! There is the moodiness, which makes the adolescent so unpredictable and such a difficult person to live with. There are the gestures of independence, which often cause one to overlook the desperate dependence which lies behind them. Our adolescent is always theorizing earnestly out of his inexperience, to reach the most preposterous conclusions (which fortunately rarely affect his behaviour); and we observe with wonder the appearance of those ethical qualities which caused Homer Lane to describe adolescence as the age of idealism and loyalty. Altogether it is rather as though an individual were here engaged, by a painful process of trial and error, in accommodating himself to a new and strange environment.

This is by no means as ludicrous a suggestion as it may seem at first sight. The adolescent finds himself confronted with such bewildering changes, both in himself and in the role which the world expects of him, that it is small wonder if he is confused. His intellectual development has gone on apace, and has far outstripped the practical experience of people and affairs which alone can give it ballast and balance. His physical development has proceeded at an even greater rate: adolescence and pre-adolescence are the periods of most rapid physical growth. And to make confusion worse confounded, the growth which occurs during adolescence is irregular. Anthropometric studies have shown that the extremities, the hands, the feet, and the nose, tend to grow more rapidly than other parts of the body at puberty. The clumsiness of the poor, embarrassed adolescent (and his sensitivity

about his appearance) are thus only too easy to understand. He not only seems to be "all thumbs and all feet", he *is* "all thumbs and all feet".

Above all there are the profound sexual changes, associated with physical changes in the glands. At first these are often unwelcome, and their outward manifestations: the development of the bust in girls, and the first traces of beard and the breaking of the voice in boys: the cause of much embarrassment. The reason for this becomes clearer in the adolescent's reaction to the more directly sexual manifestations. The onset of both menstruation and seminal emission has widespread repercussions, as a result of the general deprecation of sex in our culture. Adolescents, though often only vaguely and half-consciously, are ashamed of it, and guilty about it. These spontaneous organic processes present them with the first challenge of their carnal natures, and their response to the challenge may equally well be the first step towards healthy and intelligent acceptance:—the more common furtive and ashamed attitude, or frank sexual maladjustment. In any case they find themselves struggling with strange and disconcertingly powerful desires, and fluctuate between determined attempts to control them at all costs, and identification with what is, after all, an integral part of themselves. So the adolescent leaps from one extreme to another: from elation to depression, from asceticism to self-indulgence, from tremendous bouts of activity to complete lassitude, until at last he learns to master the new emotional forces within him.

As if this were not enough, he finds that he is now increasingly being expected to behave in a more grown-up way. "You're not a child now, you know," people are always telling him, and he begins to realize that adult-hood is by no means the idyllic condition of freedom and affluence which he had dreamed of and aspired to only a year or so before.

Part of the difficulty arises from the fact that all the privileges of adult-hood are not vouchsafed to him. If he smokes or drinks or stops out late, it is often as a defiant gesture against what he conceives to be the refusal of the established tyranny to recognize his new-found manhood. There is something in this belief of his, as anyone who cares to study the mutual relationships of the generations can soon discover for himself.

A particular deprivation which is probably of the most profound emotional significance is the lag which occurs in modern Western civilization between the attainment of full sexual maturity, and the possibility of sexual fulfilment in intercourse. There is no such delay in primitive societies; marriage usually follows close on the heels of puberty. Where, as in a tribe such as the Masai of East Africa, marriage is delayed for military reasons, a socially approved and sanctioned pattern of sexual promiscuity is established instead. The Western practice, buttressed by an economic structure which would prevent early marriages even if society approved of them, is productive of much inner stress, which must make the task of personal integration a very difficult one indeed. Out of this conflict emerges adolescent masturbation, and the "dating" and "petting" practices of the American adolescent. Yet perhaps there is some ancestral wisdom in our way of doing things, for the judgment of the adolescent about his love objects is notoriously fallible. Only too often he tends to project ideals and qualities which he admires upon the beloved, instead of seeing her as she really is. He is in love not with her but with his own subjective picture of ideal womanhood. Could it be that the experience of the centuries has taught us to make our children wait, so that at a more mature age, they make a maturer choice of a permanent partner?

The adolescent is none the less expected to shoulder the adult burden of beginning work. This can be more of an ordeal than people realize. They have often forgotten what it feels like to leave the warm, familiar and child-centred environment of the classroom to enter a factory, among adults who have no particular interest in you as a person, and display no particular consideration for you as a child—indeed rather the reverse, treating you with contempt as an inferior sort of adult. It is a cold and calculating sort of adult world in which your working life is henceforth to be spent. There comes also the realization, with something of a shock, that from now on you will be expected to become more and more self-supporting. The shelter of the paternal roof and the maternal bosom can no longer be taken for granted. Your survival is becoming your own responsibility, and this is a terrifying prospect for the young adolescent, who is beginning to appreciate only too well, in this respect at least, his own weakness and lack of experience.

Adolescence is thus inevitably a time of stress and maladjustment. In this respect it is to be contrasted with the tranquillity of the middle years of childhood, and shows a remarkable

similarity to the very earliest stage of development. Infancy and adolescence are alike in being periods when the individual is " engaged, by a painful process of trial and error, in accommodating himself to a new and strange environment ". Some of the difficulties of the adolescent in making that adjustment find their issue in those manifestations which are the very mark and essence of adolescence itself. Sometimes, perhaps where hereditary factors enter also to make the struggle even more difficult, the result is a complete withdrawal from reality; it is the age at which some forms of mental illness first begin to develop. There is still another solution which all adolescents seek at one time or another: that of regression, of refusing to grow up. This tendency can be identified in a hundred-and-one of the little incidents of their daily lives, incidents by which they seek to restore the old childhood relationship of dependence between themselves and their parents. It is reflected also in the adolescent tendency towards hero-worship, which unites in one person the adult parent-like figure and the love object from outside the family, and in the fleeting homosexuality of the adolescent, with the denial of sexual maturity which it involves. As Fritz Redl has pointed out, the adolescent gang is really an example of regression, for the natural social cell of adolescence is the smaller and more intimate group of chums, while the gang proper is typical of the pre-adolescent stage.

For some, adolescence is a more disturbing experience than for others. Much depends upon his upbringing. The child who has been overprotected at home, or maintained in a state of over-dependence by a possessive and jealous mother, will be neither emotionally oriented towards independence, nor sufficiently experienced in the ways of the world to have a fair chance of making a success of his adjustment. The institutionalized child, the product of a type of Children's Home or Orphanage which is happily becoming less common, will suffer in this way even more. The normality of the sexual adjustment of the adolescent will depend to a very great extent upon his parents having been at peace with themselves over their own sexual needs. Above all, only the sense of personal worthwhileness which comes from having experienced genuine parental love from infancy, can give him the confidence in himself which progress towards independence and maturity demands.

Something can be done during adolescence to help the child to cope with his problems. A little understanding and patience will help a good deal. The adolescent who snubs his parents is not really ungrateful, or " becoming too big for his shoes ". He is growing up, and is rather clumsy about it just yet. It is right that he should grow up, but unless he can do so with their approval, he will either cease to do so, or carry on burdened by a heavy load of guilt and to the accompaniment of many unnecessary growing pains. And remember: that embarrassment which adults often find so entertaining is genuine, and means the most exquisite agony to him. Much care also ought obviously to be taken over his vocational adjustment. On this and many other matters parents can make their influence felt if they go about it tactfully.

Among many primitive tribes, young people are subject during adolescence to a period of intensive training in the rights and responsibilities of adult-hood. These " initiatory rites " as they are called by anthropologists, give instruction in all the matters—sexual, social, religious and even the techniques of hunting or other means of earning a livelihood—to which the novice has to make his adjustment as an adult. We leave much more to chance. Although our adolescents have a more intricate and shifting society to deal with, they are thrown back much more upon their own resources. One may well wonder if this has not gone too far and whether the use of the extra year at school might not be most profitably planned with this need in mind.

With the birth of every child there is the hope that God may break further into human life than we ourselves have known. Every nativity is fraught with the messianic hope. Each generation can give its predecessor life that is more abundant. In every group therefore the elders stand in great need of what the young can give, not when we have imposed on them our pattern, but now before they have become unspontaneous replicas of what we are.

JOSEPH MCCULLOCH in " A Medway Adventure."

WHAT SATISFACTION WOULD MENTAL NURSES GAIN FROM EXERCISING TO THE FULL THEIR PERSONAL TALENTS AND PROFESSIONAL SKILLS ?

By EILEEN DELANEY, S.R.N., R.M.N.

Sister, Cassel Hospital, Richmond, Surrey.
Winner of Lord Memorial Essay Competition, 1950.

I have read this question through several times and it has given me much food for thought. One feels that perhaps the questioner meant to ask, " What satisfaction *do* Mental Nurses gain from exercising to the full their personal talents and professional skills ?" and not, " What satisfaction *would* they gain ? " Does the questioner feel that mental nurses do not exercise to the full their personal talents and skills ?

After many years of work in the mental hospitals as a trained nurse, I ask myself, have *I* exercised to the full my talents and skills such as they are ? I really don't know. Perhaps not. " What about my colleagues ? " I think of all the frustrating obstructions placed in our path, overcrowding, bad hospital buildings, shortage of staff, etc., and I realize, yes !—the questioner did mean what *would* they gain and not what *do* they gain.

" What personal talents and skills should a Mental Nurse possess ? "

(1) She should be able to tolerate anxiety. Of all forms of nursing, mental nursing is the most anxiety provoking. Anxiety is projected on to the nurse from staff, from patients, and from their relatives, and until the nurse has learned to cope with this great burden, her own emotional needs, which presumably sent her into this branch of the profession, will not be satisfied.

(2) She should be objective. Freudians feel that only an analysed person can be completely objective, and as the great majority of nurses in the mental hospitals cannot take all their anxieties to an analyst, shall we suggest that one of her personal talents should be a capacity for objectivity ?

(3) The mental nurse should love human beings as a whole, realizing their emotional needs and her own. She will be called upon to act as mother, father, lover or friend as these needs arise.

(4) She should be a sociable and cheerful person, and possess a great sense of humour, for without these three talents she could never carry on. Nurses in mental hospitals, especially in the acute wards, are expected to give a great deal of supportive therapy.

(5) She should be a neat and clean person, but not obsessionally so.

(6) It would be ideal for the trained mental nurse to possess all the skill of the trained general nurse. This is becoming increasingly apparent with the advance in modern treatments. In addition, if she is skilled in the various arts, i.e. music, dancing, games, and arts and crafts, so much for the increase in happiness for all concerned.

Satisfactions to be gained

Before we can decide what satisfactions the mental nurse is going to gain from the exercise of these talents and skills, we must ask ourselves some very portent questions.

" Why did the nurse choose this very difficult branch of the nursing profession ? "

" What emotional needs did she seek to satisfy ? "

" Did she hope to satisfy her need to give or to receive love ? "

" Was it the result of a reparative drive, or a need to sublimate a desire for dependent children ? "

Perhaps she wished to be a leader, to be powerful, to dominate others, or maybe she wanted to serve ? It might be that she wanted the security of a fairly well paid and superannuated post in the State Service. " Well, where is her satisfaction going to be obtained ? "

Her first and great satisfaction will be a wonderful insight into her own unconscious drives and problems, such an insight as can be obtained in no other work.

" Did she need to be loved and wanted ? " The mental nurse is wanted more than any other, and the almost overwhelming love that she will receive from many of her patients should more than satisfy her needs.

Her talents for leadership, power and knowledge will be satisfied if she uses them wisely. Lectures are given by tutors and psychiatrists, and once examinations are passed, opportunities present themselves for promotion into administrative posts requiring skilled leaders and teachers. These posts usually command quite satisfactory salaries and security in the National Health Service.

Last of all, did she enter the profession to satisfy her need to serve and give love ? If so, her cup of happiness will be full to overflowing. All her talents in this direction can be fully utilized. She will be completely satisfied with the endless demands on her capacity for giving love, service and support.

The exercise of her professional skills will be satisfied when her patients' relatives call to receive them back into the home once more, no longer needing her support in coping with problems which hitherto had appeared impossible to surmount.

Nurses in Mental Deficiency Colonies

What satisfaction comes the way of the nurses working in the Mental Deficiency Colonies and

Institutions ? In thinking of these nurses, I am reminded of the beautiful prayer of Ignatius Loyola, particularly of the end of the prayer, " Teach us, good Lord, to labour and not to ask for any reward, save that of knowing that we do Thy will."

Truly they serve and labour, often in old-fashioned dark and dingy institutions, fighting against great odds in their care for the happiness of these most dependent and afflicted of God's children.

Obviously, to achieve satisfaction, the nurses in these institutions must possess a real need to give; great demands will be made upon them, and this need must be their vocation.

To sum up the whole Question

Mental nursing satisfies many important emotional needs. The need for tolerance, gratitude, humour, dependency, security and leadership.

The need to mother and to be mothered, to give and to take, to serve and to be served, to create and to destroy, and that deepest of all needs to love and to be loved. This is the great unconscious need of us all. What greater satisfaction could there be for any human being, than that their work should demand and supply their need for love, without which, to quote St. Paul, one becomes as " sounding brass ".

THE NATIONAL ASSISTANCE BOARD IN ACTION

The report of the National Assistance Board* recently issued, is the first to cover a full year's administration of Part II of the National Assistance Act, 1948, and as such it is of special interest.

The Board is now responsible for weekly allowances formerly given in the form of supplementary old age pensions, unemployment assistance, outdoor relief, blind domiciliary allowances and tuberculosis treatment allowances. In addition the Board makes weekly payments to old, infirm and other persons resident in accommodation provided by Local Authorities under Part III of the Act, if the minimum charge of 21s. per week cannot be met unaided. (Every resident is, in addition, required to possess 5s. a week as pocket money so that the full sum to be made up by the Board is 26s.) In view of the numerous categories of persons to be dealt with, it is not surprising to read that by the end of 1949, 1,150,000 allowances covering the needs of about one and three-quarter million individual recipients, were being given—and this sum is exclusive of over 400,000 non-contributory old age pensions administered by the Board.

The number of unemployable mental defectives in receipt of allowances—which must by this time be large—is rather disappointingly not given as a separate category, and in the analysis of " persons receiving weekly assistance allowances " defectives presumably come merely under " Others " with the sub-heading " Persons not required to register for employment ".

The general policy of the Board with regard to the home visiting of its pensioners and other recipients of allowances is stated to be as follows:

> " The recipients of assistance include, of course, a proportion of people who need a watchful eye kept over them. The fact, however, that a minority need special attention is no reason for departing from the general principle that people who do not need such attention should not have it forced on them."

* *Obtainable from H.M. Stationery Office*, 1*s.* 9*d.*

The importance of visitations in certain cases is however fully recognized and in order to ensure a high standard in the quality of visiting, it has been decided that the greater part of it should in future be carried out by the officers responsible for decisions. Courses for Executive Officers, Area Officers and Clerical Officers, have been held, in all of which emphasis has been laid " on the importance of the way in which interviews should be conducted " and of giving applicants any help and advice needed in addition to monetary assistance.

The variety of personal problems dealt with by the Board's Officers is illustrated in an Appendix giving specimen cases. Some of these have needs which can be met (often in a completely unofficial way) by the direct services of the officer concerned, but many require referral to some specialized organization, and great importance is assigned to the establishment of good co-operation with other bodies. Presumably there is also close co-operation with Special Welfare Officers of Local Authorities whose work under Part III of the Act must often closely impinge on that of Area Officers; in some cases indeed, it is difficult to see where the dividing line is, in practice, placed. The valuable help given by members of the 83 Advisory Committees which have been set up, is noted.

Another interesting section of the Report is that dealing with " Persons without a Settled Way of Living ". Efforts made to rehabilitate men using Reception Centres, set up (to replace the old " casual wards ") under Section 17, have been disappointing, but 170 young men were sent to the two Re-establishment Centres run by voluntary bodies (at Ferryhill, Durham, and Norton Fitzwarren, Taunton), with good results. A third Centre was opened by the S.O.S. Society early in January, at Elstree.

This Report is an eminently readable and human document and it should reassure those who fear that though the Poor Law no longer exists, as such, its " taint " still persists in permeating the legislation which has succeeded it.

Mental Hygiene Clinics in the United States

By KARL F. HEISER

Co-ordinator of Professional Education, American Psychological Association.

Several years ago, professional Americans were shocked by a book which told them " where people take their troubles ".* The impression given, and to this writer's knowledge it was a true one, was that most people go for help in their personal problems to people who have no knowledge or training which would entitle them to deal constructively with such important life problems. Most people were unaware that there was a considerable body of knowledge about the psychological laws of mental health and efficiency, and of mental disorder, in the hands of a body of professionally trained persons whose work it was to deal with such problems. For lack of such public information a large number of psychological charlatans, whose chief qualifications were the ability to present either an occult appearance, or one of pseudo-professional dignity, were offering advice and treatment to troubled clients. Many of these " quacks " claimed to have academic and professional degrees which would seem to imply professional qualifications for their work, and many called themselves by titles which the gullible public thought had some relevance for dealing with their personal sufferings.

The situation in the United States, in this regard, is still serious; many people still go for help to totally unqualified practitioners, but within the past five years there have been such new developments on the psychological and psychiatric frontiers that the outlook is considerably brighter.

These new developments have been due to the efforts of an awakened public, aided by the professions of psychiatry, social work, psychology, and psychiatric nursing, to secure through private, municipal, state and federal offices a large increase in the number of agencies qualified to give adequate psychological help and an increase in the training of professional personnel to man these agencies and services. Foremost among the supporters of this development is the National Institute of Mental Health of the U.S. Public Health Service, which has disbursed millions of public moneys to States to help them expand the professional training of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses, and to students in these schools in the form of training stipends. Much of this work has been fostered, also, by professional associations, by private foundations, by public and private universities, and by States and local governments.

Knowledge of the laws of mental health and illness is still rudimentary; yet it has developed, through the studies of the four professions mentioned, to the point at which satisfaction with diagnosis on the basis of symptoms has given way to concern with causes and with effective disposition and treatment. The matter of prevention is also becoming of more and more concern to these bodies.

The British reader may be surprised at the extent of overlap in functions between psychiatrists, clinical psychologists and psychiatric social workers in American clinics. He may be confused, also, at the interchangeable use of the terms " psychiatric " and " psychological ". This may be explained by the fact that all three specialists use essentially psychological principles and methods in dealing with their problems of psychopathology and maladjustment. There is much common psychological teaching in the training schools of each group, though each brings to the joint work of the clinic team, certain peculiar specialties such as medical training, social case work experience, and standardized testing and research tools which lend to the total effectiveness of the clinic.

Services to those suffering with problems of mental health and efficiency are provided largely through centres or institutions rather than in the private office of a practitioner. This is so for two principal reasons. One is economic. Most people do not have the financial means to pay the fees in private practice. The other reason is that many of the professional people who know most about these problems believe that the pooling of knowledge and practice in a clinic or agency team will provide the best services to the client and contribute, also, to the advancement of knowledge by each of the professional team members.

* *Steiner, L. R., " Where do people take their troubles ? " Boston: Houghton Mifflin, 1945.*

The *Directory of Psychiatric Clinics*, published in 1948 by the National Committee for Mental Hygiene,* lists 801 community clinics, 291 state institutions and 50 federal agencies in the continental U.S. which offer services to the public or selected groups of people, such as veterans. This Committee defines a psychiatric clinic as "a service for ambulatory patients which has a psychiatrist in attendance at regularly scheduled hours". Most of these clinics have also the services of psychologists and social workers, who work under the professional direction of a psychiatrist or other physician.

In addition to the community clinics, mentioned above, there are a number of clinics or psychological service centres, perhaps 300, headed by psychologists, many of which have social workers on the staff and employ medical specialists in specific cases.

Altogether, then, there are approximately 1,200 clinics offering psychological services of one kind or another to non-institutionalized clients. The growth in the number of these clinics is indicated by the fact that about half of them have been established within the past five years. The Group for the Advancement of Psychiatry† states that one full-time clinic is needed for each 100,000 population. On this basis 1,500 clinics are needed in the United States. Because of the part-time basis on which most of the present clinics operate, there is now somewhat less than half the amount of such clinical services available.

Traditionally there has been a division of labour between the professional staff members. The psychiatrist has final authority in the treatment of a case and takes the responsibility for physical and mental diagnosis. The social worker prepares the case history and handles the relationships with clients and their families, or members of the public who contribute useful information or assistance in the treatment and social rehabilitation of the client. The psychologist's contribution is usually that of providing information, derived from psychological tests and procedures, which is used in diagnosis, treatment and rehabilitation of the client.

There has been a growing trend, correlated with increased training and knowledge on the part of both psychologists and social workers, to break down the division of labour, mentioned above, so that in the problems presented by the client and the particular interests and skills of the staff members, rather than their professional specialties, determine who will carry out certain functions, such as therapy. Thus, it is quite common now for the social worker or the psychologist to carry a share of the therapeutic load.

American clinics give psychological services of many different kinds, depending primarily upon the auspices under which the clinic is operated and special reasons for limitations as to clientele. The majority of community clinics are financed by local communities, their municipal and state governments, and the U.S. Public Health Service, or by joint contributions by two or more of these sources. Direction and control are in local or State hands. Most clinics are either adult mental hygiene clinics or child guidance clinics. The latter would limit themselves to children under ages 16 or 18, but there is seldom a strict adherence to the upper age limit of their clients, and treatment programmes frequently involve the parents or guardians of the child as much as they do the child himself.

The typical pattern of work of the child guidance clinic is as follows. At the first appointment the mother, who may or may not be asked to bring the child with her, is seen by the Intake Worker who is trained and experienced in psychiatric social work. She will get the essential details and history of the problem, from the mother's point of view, and will discuss them and her impressions of the case with the psychiatrist and psychologist at a staff meeting. If the problems are such as may be handled by the clinic, appointments will be made to commence treatment with either or both the child and the mother. Various considerations will determine whether the child is treated by the psychiatrist, social worker, or psychologist. In the majority of cases, the child receives treatment from one of the latter two, while the mother is seen by the psychiatrist.

During the course of treatment as much social history as may be desirable to understand the problems presented is gathered by the social worker, and she may make plans with the family or community agencies for help in the rehabilitation of the child and family. Diagnostic problems may arise during the course of treatment which are taken up by the psychologist with the aid of different psychological tests and procedures. Treatment programmes are usually

* *Now National Association for Mental Health, Inc., 1790 Broadway, New York 19, N.Y., "Directory of Psychiatric Clinics", 1948.*

† *3617 West Sixth Street, Topeka, Kansas.*

of several months' duration and may involve interviews with other members of the child's family. Treatment procedures may range from remedial reading or speech work to play therapy for the child, and from supportive, reassuring interviews to intensive courses of psychotherapy for the parent.

Not all clinics follow the above direct procedures. Many follow a rather formal system of securing complete case histories and diagnostic psychological studies before decisions are made about a case and before treatment is begun.

Frequently, the child's symptoms, which are the grounds for the first visit to the clinic, arise from parental conflict or severe psychopathy in the child's home environment. In these cases relatively little attention is given to the child, and efforts are mainly directed toward therapy and rehabilitation in the family.

Many clinics, especially those directed by psychologists or operated by departments of psychology in universities and colleges, provide a variety of non-medical services including diagnostic studies, remedial speech and reading work, re-training of those with physical handicaps, and educational, vocational and personal counselling and guidance. Severe psycho-pathological problems are not treated but are referred rather to medical or psychiatric services elsewhere.

Many American clinics, especially the larger ones connected with medical schools, psychiatric hospitals and graduate departments of psychology in some fifty universities, carry on two other important functions in addition to a service load of clients. One of these functions is research; the other is the professional training of clinical psychologists, psychiatric social workers and psychiatrists.

There is widespread recognition that research and new knowledge is of vital importance to progress in the field of mental health. Because of the great social needs for treatment and rehabilitation, much of the treatment of a psychiatric or psychological nature has been carried out with only moderate attention to the validity of the basic theoretical assumptions underlying it. Now, however, there is a demand for identification of these assumptions and for research to test them and measure the effectiveness of the different kinds of treatment programmes that have been followed. Clinical psychologists are becoming more and more involved in such research endeavours, largely because their graduate training in the science of psychology has acquainted them with the methods and techniques of research, and motivated them as to its importance in the development of their profession.

The use of psychological or psychiatric clinics for training professional workers has increased with the development and expansion of graduate education in psychiatric social work, psychiatry, and clinical psychology. It is estimated by different authorities that one psychiatrist and one clinical psychologist are needed for each 10,000 of the population. The same, or greater, need probably exists for psychiatric social workers. This would mean that 15,000 professional workers are needed in each of the three fields. At the present time there are about 5,000 members of the American Psychiatric Association, about 1,500 clinical psychologists and something over 1,000 psychiatric social workers to meet the great needs. Each of the three groups has worked energetically, and with federal support, to increase the training of specialists to fill the needs of the country's clinics, hospitals and private patients.

Thus far there has been no mechanism or agency by which American clinics may be evaluated, but the increasing degree of understanding and collaboration between the three clinical professions, usually represented in the clinics, may lead to such evaluation by joint committees, representing the professions, in the future. Various steps have been taken, however, to assure clinics and the public of adequate professional services by their personnel.

The medical profession, for example, has set standards and evaluated medical schools. Certain schools have been approved for psychiatric training. There is also a national board which awards diplomas to the best qualified men in psychology and neurology. Psychiatric social work has evaluated its professional schools and the clinical agencies in which practical training is given. The American Psychological Association evaluates graduate schools which give the Ph.D. degree to those majoring in clinical psychology. Psychology, also, has a national board of examiners which awards diplomas to clinical psychologists who have at least five years of approved post-doctoral experience and who pass the board's examinations. Thus, American clinics are able to evaluate the qualifications of their professional personnel. Up to the present, however, the salaries offered by clinics have not been sufficient, on the average, to attract many of the best qualified specialists, particularly in psychology in which the effective demands are so far in excess of supply.

News and Notes

Education of Handicapped Children

In September, the Ministry of Education issued a " Manual of Guidance " (Special Services, No. 1) for the information of Local Authorities in regard to their power to make arrangements for the education of handicapped children (1) in Independent Schools and (2) otherwise than at school.

Independent Schools

Under Section 91 of the Education Act, 1944, an Authority may pay fees for children attending Independent Schools " so far as may be authorized by arrangements approved by the Minister ". Such approval will be given under the following conditions:

(i) If no suitable place can be found in an Education Authority's Special School.

(ii) If the Authority is satisfied that the independent school concerned is suitable and arranges for the child to be medically examined at least once a year, and to be periodically visited.

(iii) If the fees are considered to be reasonable.

Where the initiative for placement comes from the Authority, no part of the cost should be allowed to fall on the parent. If, however, the parent wishes to make private arrangements with a particular school and asks for financial help in so doing, the Authority must decide the extent of such help.

Education otherwise than at School

Section 56 of the Education Act states that under " extraordinary circumstances " an Authority may arrange to provide home tuition for a child. The general arrangements under this Section will be approved by the Minister in connection with the following groups :

(*a*) Children in hospitals in which the establishment of a hospital special school is not warranted.

(*b*) Educable children whom it is inadvisable to send to school because of ill-health or whose physical disabilities make attendance impossible.

(*c*) Children awaiting vacancies in special schools, who are unable to attend a primary or secondary school pending admission.

A short period of home tuition may also be provided for a child whose educability is in doubt and for whom admission to a special school cannot be arranged.

In every case of a child under the age of five, the specific approval of the Minister must be obtained both for sending to an Independent School and for home tuition.

Copies of this memorandum may be obtained from H.M. Stationery Office, price 3d.

Training for the Adolescent Cerebral Palsied

Puckle Hill School and Training College (Shorne, Kent) was recently started to fulfil the need for further training of those handicapped by cerebral palsy, when they leave the special schools at the age of fifteen or thereabouts.

The house can accommodate 25 to 30 boys and girls. The staff include a speech therapist, a physiotherapist, a teacher of horticulture, a qualified school teacher and a handicraft teacher.

The courses running at the moment are gardening, poultry keeping and hand crafts, but as time goes on it is hoped that many others will be added. Speech therapy and physiotherapy are included in the curriculum, and are given under the direction of the medical specialist.

Students are generally taken from the age of 14 upwards, but in special cases where it is felt advisable concessions are made and they are admitted from the age of 12. The training varies according to their age and the severity of their handicap.

The College is a private venture, and the aim behind the opening of it is to take the boys and girls who, although handicapped by cerebral palsy, are of normal average intelligence and to train them to be useful and self-supporting members of the community.

Leeds Mental Health Services

Leeds is one of the few Health Authorities which has actively implemented its powers under Section 28 in regard to the prevention, and after-care of mental illness and this Report for 1949 gives an interesting account of what has been done since the passing of the National Health Service Act with photographs of the new Rehabilitation and Social Centre.

In this Centre is provided a club room, games room and library quiet room, with two rooms for handicrafts (one equipped for carpentry). A part-time handicrafts instructor was at first appointed but was later made full-time, and on certain evenings male patients at work during the day attend for instruction in addition to unemployed patients coming during working hours. The Social Club for after-care patients has proved of great value and its activities have included discussion groups and play readings in addition to games, dancing and whist drives.

A " Family Consultation Service " was set up in October, 1949 and general practitioners in the City were invited to refer patients needing psychiatric help. During the first three months after its initiation, 20 patients were so referred.

The Clinical Staff of the Department consists of a consultant psychiatrist, two psychiatric social

workers and nine mental health workers and authorized officers. Close co-operation is maintained with the University's Social Science Department, and with its Department of Preventive Medicine, and the latter has paid special attention to the instruction of Health Visitors on methods of approaching psychiatric problems.

It is, however, recorded with regret that lack of adequate child guidance facilities, other than those provided by the University Department of Psychiatry, continued throughout 1949, and therefore one essential factor in any comprehensive scheme for the prevention of mental ill-health, has been absent.

The second-half of the Report describes the work carried out for mental defectives, including two Occupation Centres for children excluded from Special Schools, a " Pioneer Laundry " for women, and a Centre for boys and men in which a variety of occupations is provided. A film showing the activities carried on in the Occupation Centres has been made and is proving of great use in arousing interest in the problem and spreading knowledge of methods used in training defectives.

This Report should be widely read as showing what can be done by a determined and progressive Health Authority despite all the difficulties of the present situation.

Social Workers in Mental Deficiency

Mr. Arthur Rose, Executive Officer, Portsmouth Mental Health Service, has prepared a simple explanation of the duties that fall to social workers in the Service in connection with mental defectives. This has been duplicated, and copies may be obtained from the Mental Health Service, Pier Hotel Buildings, Bellevue Terrace, Southsea, Hants, price 6d. post free.

The National Association has its own pamphlet on mental deficiency legislation (recently revised and reprinted) but the " bare bones " which comprise it, are in Mr. Rose's memorandum, clothed and made to live, in relation to a particular area, so that the two publications supplement each other in a very useful way.

The Red Cross and Mental Health

The International Health Bulletin of the League of Red Cross Societies made a feature of mental health in its April-June issue of 1950. The Editorial stressed the difficulty of winning " acceptance of mental health as an integral part of the economic and social welfare of the world's peoples and as a sphere for international activity and co-operation " and urged the National Red Cross Societies in countries where specialist organizations existed, to offer help in their work. In other countries pioneer work should it is recommended be undertaken, and where the need is great, a section of the national Society should be devoted to mental health and Red Cross mental health clinics should be established.

Articles are contributed by Dr. André Répond on " The Contribution which might be made by Voluntary Organizations in the Study and Solution of Problems of Mental Health ", by Dr. Kenneth Soddy (Assistant Director of the World Federation) on Mental Health and by Dr. A. Querido on the " Organization and Function of a Mental Hygiene Department ".

Dr. Soddy suggests that " the most reliable single criterion of mental health is: the capacity to live harmoniously in a changing environment ", and in a paragraph headed " Positive Mental Health " he develops this idea.

> " *Harmonious living* ", *he writes*, " *involves more than not giving offence to neighbours. A healthy person's response to life is without strain; his ambitions are within the scope of practical realization; he has a shrewd appreciation of his own strength and weaknesses. He can be helpful but can also accept aid, he is resilient in failure and level-headed in success; he is capable of friendship, and of aggressiveness when necessary. His pattern of behaviour has consistency so that he is ' true to himself ', and no one about him will feel that he makes excessive demands on his surroundings, his private beliefs and personal values are a source of strength to him.*"

" Mental health " is apt to be an elusive concept when it comes to precise definition, and Dr. Soddy's description of the mentally healthy individual would make a stimulating subject for discussion.

Copies of the Bulletin may be obtained from the League of Red Cross Societies, 8 Rue Munier-Romilly, Geneva, Switzerland. The annual subscription is 3 Swiss francs.

World Federation for Mental Health

It is now possible to enrol as an individual Associate Member of the Federation by paying an annual subscription of one guinea to include the bi-monthly Bulletin. Applications from readers of " Mental Health " are invited.

The standard rate of subscription for member-associations remains at 400 Swiss francs, but bodies unable to pay this amount should be invited to enter into an arrangement with the Executive Board to pay an agreed amount within their means. It is hoped that in this way, additional organizations with important contributions to make will link up with the Federation.

An active mental health association has been founded in the Philippines, and in the United States a step forward has been taken by the amalgamation of three bodies—the National Committee for Mental Hygiene, the National Mental Health Foundation and the Psychiatric Foundation—into one National Association for Mental Health, of which Dr. George Stevenson is Medical Director.

The Second International Congress on Mental Deficiency is to be held in New York from May 21st to 26th, 1951, during the Diamond Jubilee of the

American Association on Mental Deficiency, when amongst other important business to be discussed, is the formation of an International Society on mental deficiency with an international journal.

The next International Congress on Mental Health is to be held in Mexico in December, 1951, under the Presidency of Professor H. de B. B. Roxo, Brazil, where, but for the war, the Third Congress would have been held.

Maladjusted Children

A Committee of Inquiry into the "medical, educational and social problems relating to maladjusted children with reference to their treatment within the educational system" was set up by the Minister of Education in October, 1950.

Its members include Dr. Mildred Creak (Physician in Psychological Medicine, Great Ormond Street Hospital), Dr. Rees Thomas (Ministry of Health), Miss Clement Brown (Home Office Central Training Council for Child Care), Dr. Alfred Torrie (Medical Director of the N.A.M.H.), and Mrs. Madeleine Robinson (a London Juvenile Court Magistrate).

Although its terms of reference are limited by the words "within the educational system," the Committee's enquiries will range over a wide field including the Child Guidance Services and its Report will be a document of profound and urgent practical concern.

For Parents of Backward Children

We welcome the arrival of two new magazines intended primarily for parents of mentally defective children.

"*The Three Roses*" is the name of a society of parents of children at the Sunfield Homes, in Worcestershire, and of a magazine recently launched by this body. The first two issues contain some 26 pages of interesting reading matter with photographic illustrations. It is available for non-members of the Society at 2s. 6d. per issue, and provision is also made for admitting non-members to the Society, at a subscription of 15s. per year which includes the magazine. Applications for membership should be sent to Mrs. Hilda Jacobs, The Manor House, Berkswell, Warwickshire.

"*The Parents' Voice*" is the first printed number of the journal of the National Association of Parents of Backward Children and its appearance is another indication of the rapid growth of this vigorous Association, which now has some 18 branches.

The minimum subscription for membership, including quarterly issues of the magazine, is the very modest sum of 3s. 6d. per annum, and workers in the mental health field wishing to be kept in touch with its activities should apply to Mr. H. D. F. Hutchings, Joint Hon. Secretary, 3 Willowhayne Gardens, Worcester Park, Surrey.

Ministry of Pensions, 1949-50

The Local Offices of the Ministry of Pensions are now, we learn from the Annual Report recently published, to be termed offices of the "War Pensions Welfare Service", and the welfare activities which have been developed and extended, are described in detail. In order to equip its Welfare Officers for the more intensive social work now required of them, an advanced course on the subject has been organized.

A good relationship has been established by Welfare Officers with the voluntary bodies in their areas, and close co-operation exists between them in dealing with individual cases. The home visiting of seriously disabled pensioners has been considerably extended, and in this Welfare Officers have been helped by members of War Pensions Committee and other voluntary workers. Arising out of this development, a Homecrafts Service has been initiated and special Sub-Committees for the purpose have been formed in every region.

In an Appendix classifying recipients of Disablement Pensions at the 20 per cent. according to Disability Groups, the percentage of persons suffering from "Neurological and Mental Disabilities (excluding Epilepsy)" is given as 10 per cent. for the second world war as compared with 6·3 per cent. for the first, whilst the corresponding figures for epileptics are 0·4 per cent. and 0·6 per cent. respectively. But it is pointed out that such comparisons must be treated with caution owing to differences in classification and the fact that the 1914 figures include pensions awarded over a period of thirty years from the ending of that war. Moreover the table cannot be taken as giving a true picture of the prevalence of psychiatric illness amongst war pensioners as it does not, of course, take into account the psychiatric factor which may be an important symptom in other disabilities classified, such as "rheumatism", "respiratory diseases" and "diseases of the heart and arteries".

Art Therapy

A conference of Art Therapists was held at 39 Queen Anne Street, London (by permission of the National Association for Mental Health), on December 2nd, 1950, to consider the need for a recognised training for Art Therapy.

The chair was taken by Mr. John Trevelyan, Director of Research in Hospital Administration, King Edward's Hospital Fund. Leading Art Therapists from all parts of the country engaged in work for patients suffering from mental or physical disability, attended the Conference and participated in the discussion. Those present were particularly grateful to Dr. Irene Champernowne, Mr. Adrian Hill and Dr. J. A. Hadfield for the contributions they made.

It was agreed to set up a small Working Party to consider the selection and training of candidates, consisting of members who had worked as full-time Art Therapists for a period of not less than four years.

Reviews

Mongolism (Peristatic Amentia). By M. Engler, M.D.(Vienna), D.P.M., Assistant Medical Officer, St. Lawrence's Hospital, Caterham. Bristol, John Wright & Sons, Ltd. 21s.

Mongolism is a common condition. Several books on the subject have already been written. However, such is our ignorance of the cause and treatment of this congenital anomaly that any work which will shed fresh light on the subject is to be welcomed.

Engler's monograph is useful if only for the valuable bibliography which it provides and the excellent photographs with which it is illustrated. He has brought together in a small space a great wealth of material which he presents in a very readable manner.

The book is marred like that of Benda by the author's insistence on a particular theory of causation which, since it is unsupported by adequate data, will not carry conviction to most. The three possibilities which have received most attention to date from other workers are as follows. First there are those who seek a primarily genetic explanation for the condition. The family histories provide unpromising material from the standpoint of the geneticist and it is evident that any Mendelian explanation of the condition would be extremely complex. A second line of attack has been to seek for some lack of harmony between the parental blood groups and those of the child similar to that causing kernicterus with the Rhesus group. This approach has also been unsuccessful. A third possibility, which seems the most hopeful, is the discovery of some intra-uterine disturbance analogous to that which is now known to be produced in the embryo by German measles and toxoplasmosis, which would retard the development of the child producing a picture like that of mongolism.

Engler, however, seeks to place the blame on a degeneration of the lining of the uterus, this may be looked upon as a variant of the old theory of uterine exhaustion which can be shown on statistical grounds to be inadequate since the mongol is so frequently the first born. Engler goes so far as to state that in 90 per cent. of cases of mongolism there is some evidence of disease of the uterine mucosa. However, amongst the " evidence " of such disease he lists tuberculosis, syphilis, cachexia, alcoholism, iodine, lead and phosphorus poisoning, treatment with X-rays. If mothers who have continued to produce normal children were questioned in regard to these and many other factors capable of producing disease of the endometrium which Engler mentions it is doubtful whether even 10 per cent. of them would be regarded as having a completely normal uterus. The close identity of the clinical picture in different cases of mongolism is the most striking attribute of the condition and it will indeed be surprising if it is not shown eventually to be due to some fairly specific factor deranging the normal development of the foetus.

It is to be hoped that in a subsequent edition of his book Dr. Engler will be able to eliminate some of the inconsistencies and limitations in his presentation. Thus it is probable that more extended observation would reduce his surprisingly high figure of 8 per cent. of cases of mongolism with epilepsy. Again his use of the word " idiot " to describe mongolian imbeciles is irritating. Similarly the word feeble-minded has a definite legal significance in Britain, hence Engler's statement that " mongolian idiocy among the newborn occurs in approximately 40 to 50 per cent. of all the feeble-minded " is not only wrong but confusing. The fact that he has only seen one red-headed mongol also suggests that his material is limited.

In spite of these shortcomings the book should be read by all those interested in paediatrics or mental defect.

B.H.K.

The Backward Child. By Sir Cyril Burt, D.Litt., D.Sc., LL.D. New and Revised Edition. University of London Press. 25s.

That " The Backward Child " has reached a third edition shows how necessary this book of Sir Cyril Burt is to those who teach and have dealings with the welfare of sub-normal children.

Most psychologists appear to be detached from the physical side of the lives of their patients. Burt, however, from the time of his early appointment as Psychologist to the London County Council, links up the child's mental development with the physical and environmental aspects of life.

Burt's philosophy is reflected in this book. The first four chapters deal with classification, investigation of cases, definitions and frequency of educational retardation. There follow seven chapters on the causes of backwardness, all relating to social and physical conditions. Then come three chapters on intellectual factors. An analysis of the subject matter shows the stress placed by Professor Burt on the physical life of the child.

A careful reading changes the outlook of the teacher towards his children. He no longer sees them as just minds into which he has to pump an extra dose of the three R's; he is reminded that they have bodies. The teacher is made to realize that his pupils not only live a life in school, but they have a home and a life outside school. The book

stresses that while children need food for the mind, they also require food, clothing and relaxation for the body. Further, while boys and girls assimilate ideas at school, opportunities for first hand experience should be provided in the world outside the classroom.

The direct relationship between the functioning of the mind and the state of the physical condition of the child has been long recognized. But Burt places this factor on a scientific basis as a result of his researches among the child population of this country. With his theoretical work as a basis, the popular agitation of pioneers and the exigencies of war have led to a vast extension of school feeding, but it is to be regretted that housing conditions, of equal importance to food in the development of the child, have deteriorated since the beginning of the war.

Burt concludes his preface to this, the third edition of his book as follows:

> "*During the period of post-war construction, the treatment of the dull and backward sections of a democratic community will still remain one of the most urgent tasks to be faced.*"

To do this effectively, the size of the task has to be determined. Burt carried out his surveys on which the statistics of this book depend, between 1920-1923. Based on these figures, he calculated that 10 per cent. of the school population were backward. Since those years, a major event has taken place, namely the second world war, causing serious dislocation in the lives of our children. To what extent their education has suffered has not been generally determined.

A glimpse of what has happened is shown by an L.C.C. enquiry on reading ability among Camberwell and Lewisham children on transfer from infants to junior schools reported in 1949. Twenty per cent. had to be taught reading from the beginning, while 50 per cent. were so backward as to require special attention in reading. Burt's figures for backwardness in these two boroughs are 9·2 per cent. and 1·2 per cent. respectively.

"The Backward Child" provides an outstanding work of reference for teachers and social workers. These will not be satisfied to borrow a copy from the public library. They will find it essential to have a copy of their own, for this book answers the day-to-day problems that arise with backward children.

C.S.

Children and the Cinema. By J. C. Ward. Social Survey, Central Office of Information, Montague Mansions, London, W.1. 10s.

Children in the Cinema. By The Hon. Mrs. Robert Bower. Johns Ltd., Newport, Mon. 1s.

Since the Report on Children and the Cinema (reviewed in a previous issue of this journal), was published, there have been two related publications —a pamphlet by the Hon. Mrs. Robert Bower containing a summary of the main aspects of the Report with comments, and the results of a Social Survey carried out for the Committee which prepared the original Report.

It should be remembered that the Committee was appointed by the Home Secretary, the Secretary of State for Scotland and the Minister of Education. The mention of the first and third of these sponsors suggests that the chief enquiry was to discover what effect the cinema had on children—particularly whether it had a bad effect—and this information, one may guess, is what most people would expect from such an enquiry. If this is so, then readers of the Report and the Social Survey will be disappointed. Not only is there no evidence, but the difficulty of obtaining such evidence is apparent to those with any knowledge of research after reading these documents.

Mrs. Bower, however, is convinced that there is a strong connection between juvenile delinquency and attendance at the cinema and on this point she submitted an addendum to the Report. She offers the evidence that both are greater in Scotland than in England. Her note of unqualified certainty does not harmonize with the objective tone of the Report, and her comments and the pictures in her pamphlet, give the impression that the Report had more to say on the connection between delinquency and cinema attendance than, in fact, it had. This points to a certain danger if summaries of official Reports are made by those with minority views.

The Social Survey is a most valuable document. It claims in the introduction that, though it was not possible to study in detail the effect of the cinema on children, the broad outlines of the problem have been studied and likely fields for further and more intensive research suggested. This claim seems amply justified. The record of the Survey should be—and presumably will be—in the hands of all who in the future study any problem concerned with children and the cinema.

P.E.W.

Sociometry in France and the United States. A Symposium. Edited by Georges Gurvitch. Beacon House, 101 Park Avenue, New York, 17. $7.50.

This latest publication from Beacon House contains papers from such notable contributors as Professor Gurvitch, J. L. Moreno and Bengt Danielsson, is really a journal in hard covers, a collection of contributions all more or less about or by, J. L. Moreno and sociology, but it does show that work in both France and the United States aims at establishing a truly scientific basis for sociology. John Stuart Mill maintained that the experimental method could not be applied to the social sciences. His canon of the experimental method grew out of physics; logical aspects were emphasized, material aspects disregarded. Moreno writes that the structure of

society has an endogenous creation and development which can be studied from inside so it is the material aspect which must be stressed. With this in mind, the study of society can be subjected to scientific discipline, and the task of sociometry has been to revise the experimental method so that it can be legitimately and successfully applied to human society. Professor Gurvitch stresses the complementarity of French microsociology and American sociometry but criticizes sociometry—the application of the " Metrum " to the " Socius "—as conceived by Moreno, for the American view of the group in that it consists of the sum total of the life of its members whereas the French microsociological view is that the group has a life of its own. Which view we hold depends on our national philosophical background, the French being the obvious outcome of the thought of Comte and Durkheim, but this divergence of opinion need not prevent a convergence in a common aim.

An article like Zazzo's is tedious to read because elaborate English makes it more abstruse than the subject matter demands. If one does get through the first pages without giving up through impatience, the phrases become less pretentious, and the meaning struggles through. The records of actual field work are valuable for those of us who try to do our own, and Bengt Danielsson's on the Jibaro Indians is an admirably clear study of one of the simpler peoples. " It would be nice to know all about complicated social systems but . . . we shall never know very much about them until we have mastered the structure and functioning of simple systems." Read Bain. The method and the statistical treatment are set out clearly. Harder to read is Professor Maucorps' meticulous record of a sociometric inquiry in the French army. It is highly statistical and interesting but its elaborate diagrams are almost illegible.

The book is an extraordinary mixture, all of it is interesting and some valuable. Against an academic background the more philosophical articles fall into their right perspective, and it is these articles, plus the two others mentioned above, which give the book its value.

R.N.

The Child who Never Grew. By Pearl S. Buck. The John Day Company, 2 West 45th Street, New York, 19. $1.00.

This little book by a well-known author is being eagerly read by parents of mentally defective children in this country, in the form of a serial published by *Woman's Own*, and when an English edition is published during 1951 by Methuen's, it is sure of a great welcome.

The book has been written in order that other parents may share the writer's experience of helping a mentally defective child and bearing the sorrow of having such a child. It's theme is summed up on the first page:

> " . . . to endure is not enough. Endurance can be a harsh and bitter root in one's life, bearing poisonous and gloomy fruit, destroying other lives. Endurance is only the beginning. There must be acceptance, and the knowledge that sorrow fully accepted brings its own gifts."

To reach this goal requires a very high degree of mental and spiritual health and the book records the slow and difficult journey which had to be accomplished before it was attained.

The beginning of the way was in China—where, it is interesting to read, the people accept deformity and disability with disarming frankness and with a philosophy which accepts these things as part of life—and ends at the Vineland Training School, New Jersey. The discussion of the factors leading to the decision to place the child there, will be of special interest to parents faced with the same necessity for making a torturing decision, and the account given of the process of settling down to the new life, with the preliminary period of bewilderment and home sickness, will reassure those who are worried and disappointed when removal to an institution does not at once bring happiness and improvement.

But it is not only parents whom this moving record will help. Anyone who has to deal with the problem as a social worker, an institution staff member, an occupation centre supervisor or a medical officer, will find in it food for thought and the reading of it will deepen their sympathy and quicken their imagination. The book was, Pearl Buck tells us, a difficult one to write. We can only say to her, " thank you for writing it ".

Tender Mercy. By Lenard Kaufman. Macmillan & Co., Ltd. 9s. 6d.

If you are an Englishman you will begin by being irritated by Mr. Kaufman—I almost wrote " by having Mr. Kaufman irritate you "—such is the obtrusiveness of the American idiom when the title page has given you no inkling Mr. Kaufman is not London based.

But this mere pettifog that carps. The main irritation is the slow build-up of the tale. Mr. Kaufman is in no mood to jag his backcloth with eye-catching splashes of paint. He seems to be missing his chances : situations loom but don't develop.

The first eighty pages puts you in possession of every circumstance and every character trait necessary for the exquisite appreciation of the last 160. If you reach this point, where forces join battle, you will forgive everything to an author who marshals sentences, like forces, and spares words with the economy a strategist applies to men. Each of those later chapters ends on a thrust as crisply cut as the page you have to turn.

When you read the dust jacket, you may not be inspired. Is someone crass enough, you may ask, to try and do to idiocy what Hollywood has done to schizophrenia ? Well, no : I don't think so. The

idiot son, though faithfully and fairly delineated, is but the salient geographical feature—the Hill 60, let us say—around which some other clinical entities of psychiatry ebb and flow in battle until the Hill falls.

The other clinical entities ? Yes, there is anti-social psychopathy, black as hell : the seedy little narcissist, Rudy, compensating grotesquely for enormous inadequacies of physique and upbringing. And there's Mr. Ballard, all stable and all good. I'll swallow the all-bad man, Rudy : but I can't quite see this all-good business magnate, Sam Ballard. The other all-good one is Alice Ballard, his wife : and I'll accept her because she pays for her all-goodness by being all anxiety state. Right to the last page I thought she was inadequate and inadequately sketched. And then, in a few lines, I came to see her as the heroine of the piece, the St. Joan who received or took unto herself divine rights of action.

But it is Elizabeth, the nursemaid, who provides the most interesting and perplexing study. The publisher's writer speaks of " a penetrating study of the morality of love ". There is all that in the reactions of the Ballards. But Elizabeth gives us the reverse of the medal. You may call it, therefore, a study of the immorality of love. She is, I fancy, a high school type or, as we should say, a product of a girl's public school (though this is not explicitly stated). She has standards of honour and service and loyalty, displayed over years. And yet, and yet . . . ? Perhaps, as with Rudy, something was missing in her family, in her early life. . . . Mr. Kaufman never gave her any.

H.N.H.

(*A contrasting opinion on this book which we have received from another reviewer is as follows.*)

The problem of severe mental defect in a family is one that has not a popular appeal. Because of the painful nature of the situation, which is often incapable of alteration, the ordinary person prefers to avoid thinking of it. The subject has been treated in literature occasionally, and the play *Of Mice and Men* was a particularly understanding approach. This book, ought to be read in order that the more subtle aspects of the family environment of the severely mentally handicapped child should be understood. The fact that an American writer has written it in the usual journalistic manner and that his language at times is more crude than our sensitive ears would like, should not prevent us from appreciating the value of what he has written.

The story briefly concerns a successful business man, his wife, and their young adult idiot son, who is their only child. Their concern about his welfare and the gradual domination of their lives by the severity of his condition, is very well brought out. They have been successful in securing the services of a young woman with a sick husband, who looks after the boy and is the only one who has ever been able to manage him successfully. With everyone else he has outbursts of excitement. The return of the sick husband from hospital, and the development by him, of what amounts to emotional blackmail of the family because of the necessity of his young wife's presence there, is described with considerable dramatic force.

It would be unfair to the author to reveal the ending of this story, but from my point of view, the characters are very real. Anyone who has handled low-grade defectives, will know that their loyalty, once caught becomes very strong and one person will secure their obedience and devotion in a remarkable way. The implications of the parental attitudes to what they consider has been a reflection on themselves, are subtly brought out. It appears to me that the idiot son was aware intuitively that behind his parents' devotion was a feeling of resentment at the situation, and because of this they failed to provide for him the emotional security which would give freedom from conflict. The young nurse had an objective attitude which was honest, in that although she had pity and compassion for her charge, she also had her own personal interests. Her infatuation with her psychopathic blackmailer husband is something that does happen in real life. It is well brought out that she was aware of the evil nature of her husband, but her emotional attachment to him was something she felt was beyond her control.

The value of this book to me is that of the vividly dramatic presentation of the untold misery that is brought to a home by cases of severe mental defect cared for outside institutions and without the facilities provided by them. This is something that cannot be too often repeated. There must be thousands of homes in this country where such problems are occurring daily because of the long queue awaiting admission to institutions and colonies. In one area there are 600 cases awaiting vacancies, which only occur at a rate of about forty a year. Unless some action of an emergency nature can be taken (such as the provision of temporary buildings as in time of war), the morale of the families concerned will get lower and lower, leading to much industrial inefficiency and also to emotional sickness in those who have to cope with intolerable situations.

A.T.

Where No Light Shines. By Isanel Newitt. Sunfield Children's Homes, Clent, Worcs. 1s. 6d.

This new publication of the Sunfield Children's Homes, gives in simple language, the philosophy underlying the treatment of mentally defective children there, as in other Rudolf Steiner Homes—sometimes described as " curative education ".

Not everyone struggling with the problem of mental deficiency will be able fully to appreciate the intense ideals, which motivates Miss Newitt and her colleagues, but the pamphlet will awaken an echo in the hearts of many who long for light in a dark place, and there will be some who deal

with M.D. children in a group under conditions very different from those at Sunfield, who will be refreshed by her faith and vision even though they may not be able to accept her basic concepts.

Debby. By Max Steele. Secker & Warburg. 10s. 6d.

After a rush of novels dealing with psychiatry and psychotic patients, we are now confronted with a book in which the central figure is a mentally defective woman. This first novel was awarded the 1950 Harper Prize for an outstanding work of American fiction.

Debby—Mrs. Deborah Hall—spent seven years in an institution before being released to the care of the Merrill family in about 1927. The story tells of her fifteen years with them in the southern part of the United States, during which time she is dominated by Mrs. Merrill and, in the end, dies with the delusion that she actually is Mrs. Merrill. Parts of the book are extremely well done, especially Debby's relationships with the children and her sensitivity to the jibes and taunts of unthinking people. However, the author's portrayal of " the little childlike woman whose mental development has stopped well before adolescence " does not seem to be entirely accurate, and some of the philosophic thoughts and statements attributed to her appear to be out of character.

It is good to see that mental deficiency is at last breaking into fiction, even though Mr. Steele's attempt is not too commendable from a psychiatric point of view.

D.L.R.J.

Testament for Social Science. By Barbara Wootton. George Allen & Unwin Ltd. 15s.

This book sets out to study the extent to which scientific methods are being and can be used in the field of the social sciences. The position and reputation of the author thus must command careful attention, and the importance she attaches to the subject is reflected in her choice of a title ; she is perhaps ambitious here, and the result scarcely corresponds to any of the various meanings of testament.

Her first exposition of the problem is in clear and emphatic terms, and so are the chapters on scientific method and pre-scientific mental habits. She also very rightly describes and condemns " two blind alleys " the first of treating human societies as organisms, and the second being Marxism. Other isms are of course also condemned.

The reader is not unnaturally, but perhaps optimistically, led on to expect as logical and as clear an explanation of the ways in which practical application and progress can be made. Here the author is a little disappointing. There are, it is true, chapters on science and metaphysics, science and morals, and science and art, and these chapters are readable and picturesque ; they are also stimulating ; but they contain many highly emotional phrases, a few begged questions and some sweeping generalizations enlivened here and there by pleasant illustrations from everyday life. And her dislike of certain bodies has led her to condemn them in terms which lack the unemotional objectivity she preaches elsewhere.

Perhaps as a reaction from this, the last chapter " Conclusion " returns to the ground and the moral is drawn, valuably, of the need to keep distinct the four processes of speculation, scientific enquiry, aesthetic criticism and aesthetic experience. Mayo's criticism of lack of skill is quoted here but little effort is made to follow his instruction that social skill must be developed. If her conclusions could have been expanded and her condemnations curtailed, it would be a better balanced and ever more constructive work. But it is well worth reading.

R.F.T.

Recent Publications

WAR IN THE MIND. THE CASE BOOK OF A MEDICAL PSYCHOLOGIST. By Charles Berg, M.D., D.P.M. Macaulay Press, Southampton Street, W.C.2. 10s. 6d.

FREUD. DICTIONARY OF PSYCHOANALYSIS. Edited by Nandor Fordor and Frank Gaynor. Philosophical Library, New York. $3.75.

PSYCHOTIC ART. By Francis Reitman, M.D., D.P.M. Routledge & Kegan Paul. 16s.

THE INNER WORLD OF MAN. By Frances G. Wickes. With psychological drawings and paintings. Methuen. 21s.

THE HUMAN MIND. AN INTRODUCTORY STUDY. By S. P. Adinarayan, M.A. Professor of Philosophy, Madras Christian College. Hutchinson's University Library. 7s. 6d.

PSYCHOLOGICAL FACTORS OF PEACE AND WAR. Edited by T. H. Pear. Hutchinson. 16s.

PERSONAL AGGRESSIVENESS AND WAR. By E. F. M. Durbin and John Bowlby. Routledge & Kegan Paul. 8s. 6d.

RECENT ADVANCES IN SOCIAL MEDICINE. By A. C. Stevenson, M.D., F.R.C.P., D.P.H., Professor of Social and Preventive Medicine, Queen's University, Belfast. J. & A. Churchill Ltd. 18s.

THE PSYCHOLOGY OF INTELLIGENCE. By Jean Piaget. Routledge & Kegan Paul. 15s.

HEREDITARY GENIUS. AN ENQUIRY INTO LAWS AND CONSEQUENCES. By Francis Galton, F.R.S. Reprint of 2nd Edition, 1892. Watts & Co, 10s. 6d.

*MONGOLISM (PERISTATIC AMENTIA). By M. Engler, M.D., Assistant Medical Officer, St. Lawrence's Hospital, Caterham. John Wright & Sons Ltd., Bristol. 21s.

AN INTRODUCTION TO PERSONALITY STUDY. By Raymond B. Cattell, Research Professor in Psychology, University of Illinois. Hutchinson's University Library. 7s. 6d.

THE CHILD AND THE MAGISTRATE. Revised and largely rewritten. By John A. F. Watson. Jonathan Cape. 12s. 6d.

STERILIZATION IN NORTH CAROLINA. A SOCIOLOGICAL AND PSYCHOLOGICAL STUDY. By Moya Woodside. Geoffrey Cumberlege, Oxford University Press. 20s.

STUDIES IN READING. Vol. II. Scottish Council for Research in Education. University of London Press. 7s. 6d.

TRADITIONAL NUMBER RHYMES AND GAMES. Scottish Council for Research in Education. University of London Press. 5s.

IN AND OUT OF SCHOOL. By T. H. Etherington. Pitman. 6s.

*THE CHILD WHO NEVER GREW. By Pearl Buck. John Day Co., New York. $1.

*TENDER MERCY. By Lenard Kaufman. Macmillan & Co. 9s. 6d.

*TESTAMENT FOR SOCIAL SCIENCE. An Essay on the Application of the Scientific Method to Human Problems. By Barbara Wootton. Allen & Unwin. 15s.

THOMAS W. SALMON, PSYCHIATRIST. By Earl D. Bond, M.D. New York: W. Norton & Co. London: Chapman & Hall. 15s.

Reports and Pamphlets

MINISTRY OF EDUCATION. MANUAL OF GUIDANCE. SPECIAL SERVICES, No. 1. Education of Handicapped Children and Young Persons in Independent Schools and Otherwise than at School. H.M. Stationery Office. 3d.

MINISTRY OF LABOUR AND NATIONAL SERVICE. Report of National Youth Employment Council on work of Youth Employment Service, 1947-50. H.M. Stationery Office. 9d.

NATIONAL ASSISTANCE BOARD. Report for year ended December 31st, 1949. H.M. Stationery Office. 1s. 9d.

MINISTRY OF PENSIONS. 25th Report. April 1st, 1949, to March 31st, 1950. H.M. Stationery Office. 3s.

WAR HANDICAPPED CHILDREN. Report on the European Situation. Unesco. H.M. Stationery Office. 3s.

*CHILDREN AND THE CINEMA. An Enquiry made for the Departmental Committee by the Social Survey Department, Central Office of Information, Montague Mansions, Crawford Street, London, W.1. 10s.

*CHILDREN IN THE CINEMA. Summary of main aspects of Report and comments on points of importance to parents. By the Hon. Mrs. Robert Bower. Johns Ltd., Newport, Mon. 1s.

ORPHANAGES WITHOUT ORPHANS. By Doris Meares Mirams and THE HOME DEPRIVED CHILD. By H. C. Mathew. Printed by Timaru Herald Co. Ltd. New Zealand. 1s.

PROBLEM FAMILIES IN BRISTOL. By P. C. Wofinden, M.D., D.P.H., Deputy Medical Officer of Health. Eugenics Society and Cassell & Co. Ltd. 2s. 6d.

SOCIAL PATTERNS. Report of British National Conference on Social Work, Harrogate, 1950. National Council for Social Service, 32 Gordon Square, W.C.1. 3s.

NORTHERN IRELAND HOSPITALS AUTHORITY. First Annual Report. March 25th, 1948 to March 31st, 1949. 58 Howard Street, Belfast.

* *Reviewed in this issue*